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Mental health professionals' constructions of their clinets

Barbara Tooth
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Mental Health Professionals' Constructions of their Clients

A thesis submitted as partial fulfilment of the
requirements for the award of

Doctor of Philosophy (Clinical Psychology)



from

The University of Wollongong

by

Barbara Tooth

Department of Psychology

1993

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Abstract

How mental health services are delivered has changed significantly over the last two decades. World-wide, large custodial institutions are being dismantled in favour of the more humanistic community-based care approach. Theoretically the transition has been smooth. Unfortunately in many instances this has not been the case in practice. Many reasons for the difficulty in implementing the community care model have put forward. The lack of resources and poor networking of the services that do exist, are the two most popular of these reasons. Very little attention has been paid to one of the most fundamental elements of these services, the mental health professional. With the advent of community-based care, the multidisciplinary team approach grew out of necessity. Clients had numerous problems that required the expertise of not just one or two professionals, but many. The meanings that the members of these professions attribute to their work with clients have not been studied. Nor have the commonality and differences in client construction between mental health professionals been addressed. I have used qualitative and quantitative techniques, specifically the Repertory Grid, an interview schedule and questionnaires, to describe how psychiatrists, psychologists and nurses make sense of what they do when they work with clients. The client constructions of these three mental health professions proved more similar than different. Some of the implications of this research for the delivery of mental health services and the training of professionals are discussed.

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CHAPTER ONE

INTRODUCTION

The aim of this thesis is to examine how mental health professionals make sense of what they do when they work with clients in a mental health service. In particular I am interested in understanding how each of the professions are similar, yet different from the others, and in identifying some of the factors that may influence these similarities and differences. My experiences of working in mental health services for some ten years in two different professional roles have caused me to see this objective as very important. There appears to be much confusion and uncertainty amongst mental health professionals about their role and what is expected of them. Further, the literature provides many contradictory findings about mental health service provision that frustrate any attempt to try to make sense of what professionals do when they work with clients. There seems to be little cohesion between the different professions and surprisingly little understanding of each profession by the others. There are also many assumptions that are made about professionals and mental health services, with little evidence to support the appropriateness of these assumptions.

The current situation has arisen because of the major changes that have occurred in mental health services over the past twenty to thirty years. These changes have involved a movement away from the traditional medically-dominated hospital services to services provided in the community by many more professionals. This “scientific” and humanitarian based shift in the emphasis of care has not been accompanied by the expected improvement in the quality of care for people who have serious mental health problems. Many reasons for this less than successful transition

have been put forward, and these are summarised by Glick, Showstack, Cohen & Klar (1989). They conclude that the major obstacles to providing quality care are training factors, treatment factors, economic and administrative factors, patient and family factors and political and social factors.

There is no doubt that understanding how mental health professionals make sense of their work is a complex issue involving many variables. A theoretical framework is needed to provide an understanding of these many variables, because mental health professionals are an integral component of mental health services which cannot be ignored. In these literature reviews providing a background for the research, I shall try to look at the many variables involved in the mental health field. To do this I shall first consider the broader issues involved in service provision and then move on to consider the more specific issues in more detail.

In Chapter Two I shall focus on some of the broader issues that arise in mental health service provision. These issues include the development of community-based care and the use of multidisciplinary teams. In themselves these developments have created much controversy about their usefulness and the apparent insurmountable conflict between professions that has become integral to these new developments. Many questions have been raised about the realisation of the therapeutic ideals, with some commentators calling for a return to the medicalised way of service provision. Superimposed on these controversies is the increasing push for professionalisation of many of the new disciplines. Other factors that will be considered include organisational variables that impact on service provision, as well as

the utilisation of these mental health services. I shall also consider the wide range of difficulties that have been observed in establishing new services.

In Chapter Three I shall review the research that has addressed specific characteristics of health professionals, their clients and the professional relationship. In doing so, the outcome of therapy from the perspectives of service providers, researchers, professionals and clients will be discussed. In this Chapter I shall also describe some of the specific difficulties in establishing new services that relate to staff attitudes. In Chapter Four the role that training has played in the development of professionals, their attitudes and the problems that have arisen due to the dramatic changes that have taken place in mental health care will be discussed. In Chapter Five I will present the relevant concepts of personal construct theory. I believe this theory provides the best framework for understanding how mental health professionals make sense of their work with clients and the many variables involved in this. This theory will guide this research and the reasons for my choosing it will be discussed. In Chapter Six I shall examine some of the ways in which mental health professionals' constructions of their clients can be assessed. In this way I shall attain my overall aim of this research to understand something of how we as mental professionals make sense of our work with clients. In Chapter Seven I shall present the specific aims of this research and the research questions that have evolved as a result.

In Chapter Eight the methodology for this thesis is detailed. Chapter Nine then presents the results of my data collection and analyses. The final chapter of this thesis is devoted to the implications of

this research for mental health service provision and the training of mental health professionals.

CHAPTER TWO

MENTAL HEALTH SERVICE PROVISION

Mental health service provision for those clients who have the most severe mental health problems has changed dramatically over the last two decades. Following the advent of the introduction of psycho-active drugs in the 1950's and the major changes that took place in services for people with a mental health problem as a result, the last two decades has similarly seen a revolution in the treatment of these people. The shift in emphasis in services for mental health problems has been away from the medical approach to a psycho-social one (Geller & Munetz, 1986). This change in emphasis has meant that the service has shifted from the traditional doctor-patient one, to an approach involving many professions collaboratively offering a wide range of expertise. The health care system is becoming increasingly complex, with greater specialisation, rapid advancement of knowledge and the development of new areas of expertise and a broadening of the concept of health and illness (Sellick, 1985). Hence, due to the enormity of difficulties now known to be associated with the more serious mental health problems, the multidisciplinary team approach is now advocated as the most appropriate form of service (Sellick, 1985; Spratey, 1989; Stein & Test, 1980; Toesland, Palmer-Ganeles & Chapman, 1986).

Given the rapid development of, and changes in mental health services, it is not surprising to find that mental health principles that appeared theoretically sound have been less than successfully implemented. The multidisciplinary team approach has been questioned and even viewed as a failure by some (Brennan, 1983; Gosselin, 1985; Noon, 1988; Wilson, 1988). Reasons abound for the problems in service delivery using a multidisciplinary team

approach. Yet the systematic evaluation of these services and identification of the reasons for the problems experienced in their operation has not been fully undertaken. Armitage (1986) notes that while community-based care has many advocates and is, in fact, government policy, there have been few attempts to analyse its implicit assumptions.

Given the enormous cost to the community, both financially and socially, of the more serious mental health problems, it is surprising that so little attention has been paid to understanding the problems inherent in a comprehensive service provision. Indeed the incidence of mental health problems is high. In the United States for example 10% to 15% of the population need mental health care at any one time according to Matsunaga (1981). He further states that the current services are woefully inadequate in their ability to provide appropriate mental health services to those who require them, and that mental health services need to be commensurate with the physical health services currently provided. To achieve this Matsunaga contends that we need properly trained mental health professionals who are available when needed, services that are better co-ordinated and a greater diversity of services that are continually evaluated. He further states that "the periodic re-evaluation of the fundamental premises upon which a professional group functions is the highest form of professionalism known in modern society" (1981, p. 7).

In an evaluation of mental health services the most fundamental components of the multidisciplinary team have to be the professionals that make up the team. However researchers have addressed outcomes of intervention, theorised about what "needs"

to be done to provide appropriate services and analysed the structure needed for these services; but they have neglected the professionals and their involvement in these processes.

In my own clinical experience in the field, I found that many implicit assumptions were being made about what each profession does when they work with clients. A major and common assumption appears to be that mental health problems can be clearly labelled “for intervention by a psychologist” or “for intervention by the psychiatrist” or “most appropriate to be seen by the social worker” or “the nurse would be the best person to see this client”. The logical progression of such an assumption is that there is something unique that each profession has to offer the client. Of course this may be the case, as each undertakes a course of training that identifies them as having specific and unique skills that enables them to work in the mental health field. However one of the major issues to arise from the implementation of multidisciplinary teams is the considerable overlap that exists between the professions when they work with clients. The time is ripe for examining the similarity and differences that exist in how mental health professionals make sense of what they do when they work with clients, and to examine this in regard to their training. This information, I believe, is essential in understanding the functioning of multidisciplinary mental health teams as well as the larger community-based care movement.

In this chapter I shall address the changes that have taken place in the services for mental health clients and go on to discuss the various problems that have arisen as a result. These include the lack of agreement between each of the different types of treatment

models and the community-based care model, and the inadequate preparation of professionals to work within a community model. I shall also consider the role of organisational variables, the usage of services by clients, some of the difficulties encountered in the establishment of new services and conclude with a discussion of the current call for the remedicalisation of mental health services due to the difficulties encountered in service provision. However, before doing so, I shall provide a brief comparison between the mental health services provided in Australia, the United Kingdom and the United States of America because a majority of the literature comes from the latter two countries. Also it will provide the reader with a way of comparing my study to those in other countries.

2.1 MENTAL HEALTH CARE DELIVERY IN AUSTRALIA, THE UNITED KINGDOM AND THE UNITED STATES OF AMERICA

All countries follow the general philosophy of community-based care, hence the results from my study may be generalised to them. The current research was conducted in NSW, Australia which has a population of 5.5 million people. I shall confine my discussion here to NSW, although there is similarity in the delivery of mental health services Australia wide.

NSW is divided into 11 health care regions with most funding coming from the State Government. The Madison-Wisconsin Model of community care (Stein & Test, 1980) is the adopted model of care-based care for mental health services in this state, although only about 5 of the 11 have established comprehensive services. The Illawarra Region is one such region. It has a 24 hour mobile

treatment team, community mental health centres, psychiatric units in local general hospitals, hospital and hostel/rehabilitation accommodation for clients needing long-term care, living skills and vocational training centres, a range of group home facilities and some family intervention and support programs. The mental health services in the region are multidisciplinary. However the establishment of these services since the early 1980's has not been an easy task, and many obstacles, similar to those in other countries have been encountered (Hoult, 1990).

In the United Kingdom, mental health care is also paid for by the government's National Health Scheme which disseminates finances to local health regions/authorities (Carrier, 1990). The government has generally accepted and implemented the principle of community-based care, however there is no one identified model that has been followed which has resulted in conflict in the implementation process (Yellowlees, 1990). According to Yellowlees (1990) the Short Report (on which the principles of care are based) states that preference is to be given to services that support home life over institutional care, the pursuit of the ideals of normalisation and integration, services should be smaller rather than larger and provided locally. The large psychiatric hospitals have been in the process of winding down for some 25 years, and the consequent implementation of community-based care locally has involved the establishment of large numbers of multidisciplinary teams in community mental health centres (Yellowlees, 1990). Australia's health services are more closely aligned to those in the United Kingdom than they are to the USA because of the close historical ties between Australia and England.

In the United States of America the services are very fragmented, so comprehensive care within a single institution is not available (Marmor & Gill, 1990). According to Marmor & Gill, the USA federal government provides funds for health care but it is not directly involved in the delivery of mental health services. The federal and private funding of services has an institutional bias, resulting in the increased utilisation of community services not being reimbursed (Marmor & Gill, 1990). This leads to the “revolving door syndrome”. The USA, like Australia, has a very high proportion of its budget going to large mental health hospitals that only cater for a minority of the people who have a serious mental health problem. Similar to Australia, mental health services are provided as outpatients, but the money has not followed the client. The nature of politics in the USA make it extremely difficult to implement innovative programs. Some community mental health centres are federal programs that have state and local participation and these run efficiently (Marmor & Gill, 1990). However, due to the nature of the political system, they continue to have very complex interactions with the many agencies and jurisdictions whose responsibilities overlap. Yet as Marmor & Gill (1990) note, all countries have difficulty in moving care into the community because of the number of authorities involved. Each of these authorities have their own interests and therefore resistances are encountered.

2.2 COMMUNITY-BASED CARE

The trend towards provision of mental health care outside the hospital setting has been observed to varying degrees in different countries (Kovess & Lafleche, 1988). The community psychiatry

movement grew out of the re-examination of psychiatric hospitals which were perceived as having a negative effect on clients (Mechanic, 1980). They were seen to produce isolation and stigmatisation of clients which lessened their chance of re-integration into the community. The movement called for the closure of large psychiatric hospitals and the creation of small intensive care units, care in general hospitals, and particularly in the community so that clients could maintain contact with their families and their normal environment (Geller & Munetz, 1986).

The community psychiatry movement led to a revision of care models, the involvement of a large range of professions in mental health care and the recognition of the need for multidisciplinary community treatment teams (Kovess & Lafleche, 1988). There was also the need to create a comprehensive system that serves the individual needs of the consumer. This led to the development of various models of care in the community. It does appear that each of these models has a role. However, claiming that one is superior to the others should be viewed as suspect; because more informed consumer choices might increase the appropriate utilisation of services and so improve specific service outcomes (Pfeiffer & Mostek, 1991).

Stein & Test (1980), some of the most influential evaluators of the community movement, emphasise that programs should: use an assertive approach, be individually tailored, exist in vivo, capitalise on the patients' strengths, gradually reduce support, relate to clients as responsible citizens, and have crisis resolution services available 24 hours a day. Similarly Burti, Garzotto, Siciliani, Zimmermann-Tansella & Tansella (1986) in their evaluation of

community services in Italy, found that efficient integrated community services providing crisis intervention and long-term extramural care were able to treat even those people who had the most serious mental health problems who would normally remain in closed institutions. Yet even with such clear guide-lines and obvious success, the overall results of such services are disappointing, with high client recidivism, low staff morale, and few apparent successes (Malone, 1989). Malone concludes that the principles of traditional therapy for the long term seriously mentally ill are incongruent with most existing clinical treatment regimes.

A study of the realisation of therapeutic community ideals by Bell & Ryan (1985) indicated that staff in psychoanalytic, biological and rehabilitation orientated settings shared many beliefs about the ideal milieu, but only the staff in the rehabilitation setting were able to reach these ideals. These authors believe this is due to the psychoanalytic and biological modalities being discordant with those of the therapeutic community. That is, the philosophy of care of the rehabilitation setting was a much better fit with the service model. So even if staff are similar in their goals, if the treatment philosophy is incompatible with the treatment setting, then success will be limited. This, on top of inadequate funding and research that indicates clients with a case manager actually used more services, were hospitalised more, but showed no difference in their quality of life, has led to hopelessness being pervasive among mental health professionals (Harding, Brooks, Ashikaga, Strauss & Breier, 1987).

The disappointing results of community care teams in Canada have also been reviewed by Kovess & Lafleche (1988). They found that the practice of community psychiatry had become a medical model based on individual therapy. The time that professionals spent in community activities was low and provided a source of dissatisfaction for all of them. They also found precedence was given to the individual relationship between therapist and client, more than to interventions within the community; a far cry from the community model of care. However they did find a true team effort with each profession actively participating in taking on cases and, in this respect, the teams operated closer to the community model. Other authors (Olshansky, 1980; Spiro, 1982) have found that the therapy models in community care are taken from those for the "worried well", a further complication to providing appropriate care. These findings may indicate that the professionals involved in community care have been inadequately prepared for the work required of them.

A more sociological approach to the problems in the community movement is that of Gergen (1990). He is concerned with the paradox of the prevailing concern for human betterment and the pervasive dependency of people on these professions for improving their lot. According to Gergen this leads to the professions generating increased entanglements that are self-serving for the professions, but add what he calls the existing sense of deficit. That is, professionals create behaviours that are viewed as deficits when they once were not, thereby creating an increasing population of patients which in turn forces the professions to expand. More problems are constructed, and more help is sought, and so the cycle goes on. Gergen (1990) advocates breaking this

cycle by addressing our use of language and shifting the blame from the individual to the group, as there are no problems of behaviour independent of arrangements of social interdependency.

It would appear that overall the community movement has much to offer in providing a framework for mental health service provision, but the difficulties in establishing successful services of this kind cannot be ignored. I shall now review the literature on one of the major components of the community movement, multidisciplinary teams.

2.3 MULTIDISCIPLINARY TEAMS

Multidisciplinary teams are commonplace (Sellick, 1985; Toesland, Palmer-Ganeles & Chapman, 1986) and much studied (Brennan, 1983). Some research reveals multidisciplinary teams as the most effective service option for mental health clients and appears to support very defined roles for each profession (Porter, 1988). However there is wide disagreement about whether multidisciplinary teams actually do contribute significantly to improvements in patient care or if they produce fragmentation of traditional psychiatric services (Krupinski & Lippmann, 1984). As previously stated, the multidisciplinary team approach is considered superior to individual treatment due to the high prevalence of the most serious mental health problems that psychiatrists alone can not treat. Yet the teams also developed for ideological, financial and resource reasons. Such teams are advocated as the most appropriate method of service delivery and assumed to provide better co-ordination of different professions, clearer and more equitable division of labour, a holistic approach to the development of treatment plans, a stimulating environment

for professionals and increase team support (Ovretveit, 1986). It would appear that such ideals are rarely achieved with many reasons for this situation put forward.

The role of each type of professional has not been clearly understood, with senior people in the teams unable to be clear about the specific contributions each could make (Krupinski & Lippmann, 1984). Certainly, initially all professional staff would be generalists of equal status and would share their specialist knowledge with each other and reach consensus on policy decision. It is also common practice for these teams to advertise for generalist mental health workers that can be drawn from many professions. A non-hierarchical organisation structure has also been favoured. Yet in practice, although the teams started off as generalist, differences between the professions emerged. Krupinski & Lippmann (1984) found that nurses had the highest caseloads and usually those clients requiring medications, while other professions had more clients requiring family work and psychoeducation. Occupational therapists and social workers were also more involved in community activities. Similar results to these have been found by Woof, Goldberg & Fryers (1988). Krupinski & Lippmann (1984) have observed a process in the team that is all too familiar to me. During the first year of operation team members expand their expertise by learning from one another; however over time staff revert to their own profession due to the stress of having to be everything to everyone. Additionally conflict between the team and other service groups add further stress to team members. Thus greater flexibility also leads to greater stress.

Dingwall (1980) has identified both the internal and external pressures that work against successful multidisciplinary functioning. Interpersonal difficulties result in cliques and covert power struggles (Ramon, 1989). The quality of the interactions between professions is crucial to maintaining good standards of care (Gosselin, 1983; Molin & Herskowitz, 1986). Other authors (Gosselin, 1985; Roberts, 1985) have noted that in most cases psychiatrists have been reduced to the writing of prescriptions as they are usually left with the sickest clients to see and less time to see them. This has resulted in a greater number of prescriptions being written as they do not know the clients well. Such situations have lead to a call for psychiatrists to take over leadership of mental health teams.

The research on the structure, administration and functioning of multidisciplinary teams is similarly contradictory. Spratey (1989) advocates that teams should contain no more than 6-10 members to be effective. Larger teams make close support and supervision difficult, which results in divisions within the team. Spratey states that it takes many years to develop into an effective team and the team must have the six "C's": clarity, congruence of purpose, competence, confidence, continuity and a caring attitude. Brink (1984) has noted that all members of a team in Palo Alto California felt good about the team. It functioned on the premise that wellness was the responsibility of the individual and the professional's role was to assist the client to do this. Brink was impressed by the great respect everyone had for everyone else's insights and potential contributions. The team's success was attributed to the fact that no-one was set up as "the authority", which led to creative problem solving. From my own observations

however, the Palo Alto treatment team is not typical of most mental health teams. At Palo Alto they appear to have adopted a very effective therapeutic team approach that is little realised elsewhere.

The advantages of these teams in terms of meeting clients' needs, offering better treatment programs and providing a stimulating and satisfying environment for workers, appear to be far outweighed by their disadvantages (Toesland et al., 1986). The disadvantages are that there is much pressure for team members to conform, which limits creative thinking. This may also cause agreement with poor decisions. The decision making process has also been noted to be time consuming, communication to be difficult among team members and their roles in the decision-making unclear. The major issues raised by these authors were the need to determine if the team members' roles should be clearly defined or more ambiguous, and whether the distribution of power should be equal. This suggestion is in contradiction to the original philosophy of the generalist worker being preferred in multidisciplinary teams, but it is also one that is frequently made.

Indeed there is a common theme in the literature of the poor functioning of multidisciplinary teams. Soni, Steers & Warne (1989) found that 40% of the team's time was spent on administration and group activities and only 25% on patient care. This results in a denial of care to those clients most in need, who are the very clients that the teams were set up to help. According to these authors many factors contribute to the failure of multidisciplinary teams and these include the structure, establishment, inadequate funding of physical and human

resources, and political and non-political controls over the teams. They also note that the tighter the control over the team the greater the difficulties and the wider the gaps in meeting the needs of the clients. They advocate clearly defining the role of team managers and their control over the team as well as providing on-going staff education and supervision. They believe clinical decisions should be left to the team with an emphasis of shared responsibility to stop team division. Such principles are advocated by others (Marshall, Preston-Shoot & Wincott, 1979).

Other problems noted in multidisciplinary teams are the integration of members due to the segmented training of each profession which leads to differences in ideology, values, attitudes, jargon and orientation to health care (Sellick, 1985). Sellick states this often leads to conflicts rather than to high quality care, as each goes into the team with a clear idea of how other professions function. A lack of clarity leads to confusion, role conflict and role overlap. However Sellick also notes that this is difficult because there is much lack of agreement as to what the functions of each profession are.

Wilson (1988) believes that the extent to which multidisciplinary teams are under siege is underestimated. He states that the emotional demands on them are high and that unless the burden is acknowledged both by those within the professions, and those responsible outside for service provision, multidisciplinary collaboration will always be precarious and inadequately developed. Wilson states that team members retreat into professional isolation as a way of coping with the considerable stress and this further undermines collaboration. To overcome this

he advocates revision of the training of professionals and service providers, as the existing structures do little to foster multidisciplinary functioning. Wilson also believes that health professionals should undertake a “core” of training that is common for each profession, as we need greater integration of professions during training with the hoped result of specialties being better understood and tolerated. Training is essential for good quality of care (Gosselin, 1985). Indeed the training of mental health professionals is one of the central issues that needs to be addressed, if effective community care is to succeed. These training issues are of course tightly interwoven with professional issues.

2.4 THE PROFESSIONALISATION OF MENTAL HEALTH PROFESSIONALS

The role confusion and ambiguity is further compounded by the fact that the professions are not viewed as having equal status. In many teams the higher status of the doctor is usually reinforced by the team (Lynch, 1981). This inequality is due to some professions not reaching adequate professional regulation and recognition, hence their services are still far away from accepted standards (Gosselin, 1985). However, consumers of health care services are rightfully gaining increasing power in the development of services and they may view the increasing attention to credentials and competition amongst the professions as involving turf battles. Such professionalisation activities have very little to do with the welfare of the public (Hendrick, 1985). Indeed the public may view professionals as promoting the profession rather than protecting the public. I must agree with Hendrick who concludes that we as

professionals should be demonstrating professionalism rather than entrepreneurialism by providing various types of services in alternate settings. Professionals are suffering a public image problem on the one hand and an identity crisis on the other (Wiezalis, 1984).

One outcome is clear. If we cannot resolve the differences ourselves, patient care will be taken out of our hands by the bureaucrats and the political issues will take precedence over clinical assessment, treatment plans and processes as well as outcome (Gosselin, 1985; Roberts, 1985). Another area that must be addressed is training of staff that can lead to a more coordinated multidisciplinary input.

2.5 DEMANDS FOR IMPROVED TRAINING OF MENTAL HEALTH PROFESSIONALS

Some of the criticisms regarding the training of professionals to work in the community have already been put forward. The community movement has thrown health professionals together in unanticipated ways as they are not typically trained to think of collaboration with other professionals. However, if change is to come, then professionals will have to examine their own needs and problems, and question both their training and the theories that guide their practice (Hatfield, 1986). In a similar vein Malone (1989) states that, in general, mental health professionals are not trained to meet the needs of those clients who have the more serious mental health problems. Lamb (1988) also refers to the need to train professionals to take an individualistic approach to working with these clients. He states that this did not happen in institutions and it may well not happen in the community. At first

it may seem that Lamb is at odds with the ideals of the community movement, but I believe he is referring to taking a holistic approach to clients rather than the narrower individualistic approach that may be implied. Further training will need to address the realities of day to day living rather than trying to aim for a change in character. To do this trainees will have to have treatment goals. They will need to be able to help clients understand their reactions to stress, be flexible, and be able to establish a warm and meaningful relationship with the clients.

With regards to psychiatry, many changes have taken place within the profession and it has expanded greatly from the 1950's and early 1960's. Therefore there has been a great need for innovation. In psychiatry it would appear that community mental health theories have given way to a greater emphasis on the biomedical model and the current economic crisis has caused a decrease in the alternate treatment available (Brown, 1986). Another recent change described by Brown (1986) is that psychiatrists are also trying to align with mainstream medicine. McCarley, Steinberg, Spears & Essock-Vitale, (1987) have traced the progression of changes within psychiatry and report that while there was much difference between psychiatrists who were psychologic/analytic versus directive/organic in the 1950's and 60's, this fragmentation has dramatically decreased with much more overlap evident. These authors also report that training is becoming much more uniform, yet further research indicated that there were still differences between the two groups in a number of areas. They conclude that psychiatry is becoming progressively more biologically orientated. However it is interesting to note that in their sample 79% of participants strongly agreed that the success of psychotherapy was

due to the therapeutic relationship, rather than to any underlying theoretical framework. Also 90% of those who were analytically orientated practiced privately. With the rise of biopsychiatry, public health psychiatry may be more attractive to doctors who do not adhere to the liberal tenets of community psychiatry, and those who do may well be those in private practice.

Similarly, psychologists undertaking counselling roles have traditionally seen the less severely disturbed client population. However the change in the health care system and the current economic environment have led to an increase in the severity of emotional and behavioural problems presenting to counselling psychologists. The increase pressure on professionals to provide services such as diagnosis and assessment has prompted Robbins, May, Corazzini (1985) to call for improved training. They contend that training should emphasise these skills as well as traditional therapy skills and offer more opportunities for specialty training.

With regard to nursing staff, a review of the literature reports a recurrent theme that nurses are resistant to traditional modes of care for those with the more serious mental health problems and, due to a lack of conceptual models, have adopted a pseudo psychologist or social work role (Malone, 1989). Malone goes on to report that nurses should examine their theoretical bases for practice and go back to the traditional notion of nursing "being practical". Such actions imply a push to identify nurses' knowledge base as separate and distinct from other mental health professions. The current movement of nurse education to the university sector sanctioned such moves. This is another proposition in contradiction to those proposed by the community health

movement that advocates more generalist roles. It also highlights the dilemma of the push for professional identity on the one hand, while on the other there is a rational call for more generalist professionals if quality and integrated care is to be provided.

Again the problems in health care service provision are calling for greater specialisation, and as I have already stated this is a position contradictory to the tenets of the community mental health movement. The issues of training are very complex and will be dealt with in greater detail in Chapter 4.

2.6 THE EFFECTS OF ORGANISATIONAL VARIABLES ON SERVICE PROVISION

The subtle but significant impact of ecological parameters on the interpersonal processes in mental health settings was first studied by Sommer (1969). Since then one of the most reliable ecological predictors of mental health service function has been that of organisational size (Balla, 1976; Landesman-Dwyer, Sackett & Kleinman, 1980; Prien, Jones, Miller, Gulkin & Sutherland, 1979; Segal & Aviram, 1978; Weihl, 1981). Organisational size is an issue in mental health services, because the new treatment approaches advocate a movement away from care provided by one professional, to care provided by larger teams with a greater networking with other services. At the same time large institutions are being dismantled to form smaller service centres.

So while the treatment approach is expanding, the size of treatment setting is decreasing. In reviewing the available literature on organisational size, Hellman, Greene, Morrison & Abramowitz (1985) concur with the view of Hare (1981) who postulates three

universal socio-psychological consequences of an increase in organisational size. The first is heightened anxiety, vulnerability and inhibition among all participants. The second is a decrease in the members' identification of and commitment to the organisation; and the third is an increase in psychological distance. I would argue that, even though the treatment setting is decreasing in size, the amount of resources spent on organisation of mental health services is increasing.

Hellman (et al., 1985) claims that these effects impair the ability of the groups to achieve designated tasks. Their work indicates that organisational size appreciably affects members' views of themselves and the psychosocial environment, ultimately resulting in an overall adverse reaction to the larger social system. The larger setting also evokes more intense anxiety and interferes with the individual's capacity to preserve a sense of personal worth and effectiveness. In the large organisations studied by these authors, they also found greater psychological distancing between staff and the organisation and between same-status subgroups and other-status subgroups. These findings are consistent with those presented earlier, and support the need to keep multidisciplinary teams small.

Staff responses to the behaviour of severely disabled adults have also been studied across four large institutional settings, three large community units and five small community houses (Felce et al., 1987; Warren & Mondy, 1971). The findings of these studies suggest that institutional size is an important factor in determining how staff respond to clients. Staff in large institutions consistently have poorer interaction with clients, while those in smaller settings

show a greater level of encouragement of clients. Again these results support the move from large institutional care to more individualised care in smaller settings. The next section will look more closely at the effects that the changes in health care have had on professionals.

2.7 THE EFFECTS OF SERVICE PROVISION ON PROFESSIONALS

The variables involved in burn-out in professional staff have claimed the attention of numerous researchers (Maslach, 1982; Maslach & Jackson, 1981; Maslach & Pines, 1977; Pines & Kafry, 1978; Pines & Maslach, 1976; Savicki & Cooley, 1982; Savicki & Cooley, 1983). In a more recent study, Savicki & Cooley (1987) have found low levels of burn-out in work environments where the workers are strongly committed to their work, co-worker relationships are encouraged and supervisory relationships are supportive. In contrast, high levels of burn-out were found where there is a high personal adherence to work through restriction of worker freedom, where flexibility is demanded, and planning and efficiency are de-emphasised. Also, jobs that are vague or ambiguous in regard to expectations and where management impose extensive rules and regulations to constrain employees, and where support and encouragement are low, appear to contribute to burn-out.

An important point made by Savicki & Cooley (1987) is that role differences in the organisation can lead to burn-out. The differing demands, such as those for professionals who have high contact with clients versus those who have low contact, is an example. Another finding by Oberlander (1990) is that the staff working with those clients who have the more serious mental health

problems are vulnerable to dissatisfaction and stress. Satisfaction is needed for agencies to be productive and stable, otherwise treatment outcome will be affected. Therefore treatment goals need to be well defined by service agencies. As I have mentioned elsewhere, these findings have important implications for the difference in functioning of multidisciplinary teams and in-patient treatment settings. The settings are often those just described as leading to high levels of burn-out.

A study conducted by Savage, Cullen, Kirchhoff, Pugh & Foreman (1987), addressed the conflict that arises in nurses between their value system and the practices they are required to perform. Such conflict is seen to lead to burn-out. The somewhat surprising result from their work was that nurses were more likely to comply with "do not resuscitate" orders according to what others thought of them rather than on their own values. The authors of this study hypothesize that this subjective norm exerts more weight in situations where a specific professional behaviour is prescribed by another discipline.

Another important variable therefore appears to be what each profession believes they are required to do, independent of what they may actually view as appropriate. This is supported by the study of hospital doctors' management of psychological problems (Mayou & Smith, 1986). Nearly half the doctors felt that although psychological problems were important, they should not concern themselves with them. Of the physicians who acknowledged the importance of psychological care, a significant number wanted to deal with it themselves and saw it as a medical responsibility rather than a nursing one. Yet over half wanted more contact with

psychiatric services, but did not refer clients to them as they thought the clients disliked it. This was partly due to the disadvantages of being labelled as a psychiatric case and also to the perceived ineffectiveness of psychiatric treatment. The overall satisfaction with those services that are provided by other professionals has been strongly related to diagnostic agreement between the groups concerned (Olson et al., 1988). That is, it would appear that referral agents need validation of their referral to accept the service provided.

2.8 STUDIES OF THE UTILISATION OF MENTAL HEALTH SERVICES BY CLIENTS

There is a need to look at, as well as the issues already discussed, the factors that influence service use by clients. There appears no point in assessing mental health services if they do not address clients' needs. The utilisation of mental health services by clients in minority groups has received attention in recent years. Minority groups have been found to use alternate sources of help such as a general practitioner, clergy and traditional healers in preference to traditional mental health services (Flaskerud, 1986a). According to Snow (1983) this is because these alternate helpers share the same world view as the clients, make diagnoses that seem appropriate to that world view and use treatments that both practically and symbolically put the client back into balance physically, socially and spiritually.

Apart from the problems of utilisation of mental health services by clients, another issue is the changing role of the client in these services. At a time when mental health professionals feel under threat due to decreased status, budget cuts, and lost job security,

clients are becoming more empowered. Clients have a much greater say in their treatment and are represented on many policy making boards (Silva, 1990). In Australia the Health Ministers have adopted a statement of rights and responsibilities for clients, clearly legitimating the increased power of clients (Report of the Mental Health Consumer Outcomes Task Force, 1991). Silva suggests that clients become frustrated with the slow changes and so argue with, rather than collaborate with, service providers. Instead of viewing the changes as a threat to either party, Silva advocates more careful planning of services with increased consumer involvement and a careful look at the various roles that are created in a comprehensive mental health service.

2.9 DIFFICULTIES IN ESTABLISHING NEW SERVICES

Winter et al. (1987), in their study of a psychiatric crisis intervention service, pointed to the difficulty in establishing new treatment interventions. Winter's work is highly relevant here, but as it deals mainly with staff attitudes which are the focus of my research, it will be dealt with in more detail in the next chapter. This section identifies those difficulties that have arisen due to changes in mental health services at an organisational level.

The considerable resistance, emotional conflict and high staff turnover when trying to develop therapeutic communities has been addressed by Ziegenfuss (1986). He reports that while nurses used to just support other staff, now it is becoming increasingly acknowledged that nurses should spend a lot of time with clients. Although some are trained in counselling, it is not as many as those doing this work. They have increased job responsibilities and participation, and, although highly motivated, they need much

more support during this transition period. Nurses who do not have therapeutic skills are undercut by professionals who do and often they feel they are losing control of their jobs.

Other authors (Miller, 1974; Carl & Jurkovic, 1983) have concluded that interinstitutional conflict has impeded the application of promising ameliorative techniques in organisations. They state that rather than addressing these difficulties in terms of conflict between the organisation and clients, we should focus on the relationship between organisations. There has also been considerable difficulty in providing treatment in a maximum security psychiatric unit, as Quinsey, Cyr & Lavalley (1988) have shown. These authors claim that historically there has been little control over admissions or discharges. They also argue that a clear rationale for treatment programming leads directly to serious disagreements amongst professionals, profound pessimism about treatment efficiency in general, and a lack of emphasis on client assessment and on variables that may be related to the client's ability to be treated and provided with proper program selection. Increasingly the problems identified in the establishment of new services is leading to a call for the remedicalisation of mental health services.

2.10 PROFESSIONAL DOMINANCE AND REMEDICALISATION OF MENTAL HEALTH SERVICES

The often made claim that the power of the medical profession is responsible for a lot of the conflict that occurs in the health system, may be only a superficial account of a much more complex problem. This is supported by the work of Raven (1986) who states that researchers soon learn to be cautious in asking health

professionals about power, as they become defensive as power carries surplus meaning. The social psychology definition is more general, stating that power is the ability to influence, to induce change in attitudes, beliefs, emotions or behaviours. As such all relationships involve power. There are also many types of power that may be used differently by different professions. It appears that psychiatry, being more advanced as a profession, may be able to be more cohesive as a group and rally together to push for tighter controls on mental health services. The following illustration shows how this is being done.

The history of the social development of psychiatry is provided by Hill (1983). The undermining of the traditional hierarchical structure began after World War II, with the introduction of the professions of psychology and social work and it has only been recently that these professions have not been considered as aides to psychiatrists. At the same time as these changes were taking place, psychiatry lost its credibility within medicine, as there appeared to be a lack of clear understanding by the profession of mental illness. The move back by psychiatry into medicine, in an attempt to greatly influence it, has failed. Instead psychiatry as a result has become medicalised. The psychological disorder in general hospital patients is high yet there is much reluctance to refer to psychiatrists because physicians are sceptical and patients dislike it. For Hill, present day psychiatry is only possible with collaboration and team-work that depends on goodwill.

Hill (1983) takes the stance that psychiatry must assess its role in medicine and society, define the qualities of a good psychiatrist and they must work with other team members. But as Hill points

out, there is also a push in legal circles to control psychiatrists' practice by external committees that have a strong lay membership. This push advocates that each patient should have their own lawyer to protect their rights. Hill states that psychiatrists must abandon any pretence to an authoritarian role that has been inherited from history and all professions should start working together and recognise their own limitations. Yet Hill still advocates that psychiatrists should push for the leadership role in multidisciplinary teams to provide "a bridge across disciplines".

A similar point is made by Quadrio (1988) who argues that the current dissatisfaction with psychiatry has led many to be tempted to remedicalise their profession. This she views as regression rather than progression and suggests that psychiatrists may need to re-educate themselves, as many professions can equally perform their duties, and sometimes even better. She further states that new psychiatrists are less equipped than a junior social worker in both interviewing and counselling skills, but more equipped in diagnosis and the prescription of drugs. Quadrio comments on the increased power of consumers, whom she states, vote with their feet if treatment is not meaningful to them. It is her premise that psychiatrists must "tough it out" with others and listen to the wishes and needs of customers. However, she also believes psychiatrists should convince the bureaucrats that they are uniquely qualified and best equipped to deal with mental health problems because they are the best equipped profession to understand the mind-body interaction.

Raphael (1986) has suggested that psychiatry has failed to recognise or take account of the cultural, subcultural and societal issues that affect clients and that perhaps psychiatry now needs to look to prevention far more seriously. She points out that the life experiences of psychiatrists are mostly very different to the vast majority of clients who need their help. As a consequence, they are often faced with clients they feel they cannot help because of their “real life” situations in which psychiatrists feel helpless, and refer to social workers. She advocates a reorientation to prevention to avert the above situation. Raphael concludes that training needs to equip psychiatrists, but also they should not abdicate their jobs to those who are less skilled. She contends that other professions have only been shown to be effective with some disorders in some settings. Unfortunately I believe that this argument can be equally applied to psychiatrists.

The challenge to medicine’s dominance in mental health services in the late 1960’s from both within and outside the profession has been reviewed by Ritchey, Pinkston, Goldbaum & Heerten (1989). These authors state that as medical dominance waned, other occupations saw opportunities to increase their professional status and to lessen the alienation inherent in the bureaucratic setting where medicine was practiced. Indeed there are many accounts of the changing face of medicine in relation to other professions.

Ritchey et al. (1989) believe that perhaps now, more than any other time since the turn of the century, the medical profession encounters potential boundary disputes with other health professions. As Twaddle & Hessler (1987) describe: “as new technologies/techniques arise the medical profession regulates

them until it is clear which tasks may be deregulated, or abandoned to subordinates” (p. 210-211). Ritchey et al. (1989) equate this to medical practitioners being the “captain of the ship” and state that “the ship is much larger and more organisationally complex. From a functionalist perspective the team approach to medical care and an hierarchy authority structure are inevitable” (p. 78).

All of these authors still appear to be advocating the psychiatrist’s prominent position in mental health services, while at the same time advocating greater collaboration with other professions if services are to be fruitful. Again the contradiction between the ideals of the community movement in mental health services and the ideals of those that make up the service is apparent.

2.11 SUMMARY

This chapter has provided a context for understanding the present day working environment of mental health professionals. I have looked at the changes that have taken place in the provision of services and addressed the problems that have arisen as a result. Some of the important issues raised include: the lack of agreement of some service models with the community-based care model; the feelings of helplessness of professionals as well as their inadequate preparation to work in multidisciplinary teams; the difference between the ideals of the community movement and the reality of service provision that at times appear contradictory; and the importance of the training of professionals if mental health service provision is to be successful. What has been neglected so far in developing an understanding of service provision, is an understanding of the role of professionals and their relationships

with their clients. The next chapter provides an overview of some of the research that deals with that relationship.

CHAPTER THREE

STUDIES OF MENTAL HEALTH PROFESSIONAL- CLIENT RELATIONSHIPS

In reviewing the literature on professional-client relationships in mental health services, what is striking is the sporadic and rather ad hoc attention given to professionals in the relationship. The research does not appear to be theory driven and the many variables involved in the professional relationship have not been studied in any systematic way. Frayn (1968) points out most of the studies have focussed on either the outcome or process of therapy, with client characteristics receiving the most attention. However he postulated that professional personality traits should be the focus of attention for both practical and theoretical reasons. It is my position that the personal meanings that professionals attribute to their work is what is important. It is tempting to speculate on the reasons for the neglect in the literature of studying either the characteristics or the personal meanings of mental health professionals, but to do so one must first present what has been attended to in past research in order to lay the groundwork for such speculations.

This chapter provides a review of the literature that illustrates the complexity of studying characteristics of professionals, or therapists, as they are often called. In doing so, my focus will therefore be skewed towards studies that are more interested in these characteristics. I shall begin by addressing some of the studies on the characteristics of successful therapists, then go on to discuss research on the process of psychotherapy, the interpersonal relationship between professional and client and then look at the outcome of psychotherapy. In the next section I shall review some of the studies of the differences between natural and professional therapists, then go on to address studies that look

at the values and perceptions of professional therapists. Following this I focus on the changes in attitudes that have taken place amongst professionals towards the aetiology and treatment of mental health problems. In the last section of this chapter I shall address the more specific difficulties in establishing new services as they relate to professional attitudes. I close by speculating on the reasons for neglect by researchers of the characteristics of professionals and discuss the practical and theoretical implications of this neglect for service provision.

3.1 STUDIES OF THE CHARACTERISTICS OF SUCCESSFUL THERAPISTS

The importance of studying therapist characteristics is exemplified by Eptein (1963) who contended that the most significant factor contributing to therapeutic ability is the therapists' personality, because poor therapists do not improve in their ability but they can make clients worse. Similarly Coombs (1986a; 1986b) states that we should investigate the perceptual organisation or belief systems of effective therapists rather than focus on facts, methods or behaviour. Yet he notes the disappointing results of the search for definitive personality characteristics of effective therapists. Hyman & Woog (1989) have similarly found that those therapists who are governed more by internal, complex, ambiguous factors and are more searching and open to experiment, are more effective therapists. That is, flexibility appears to be an important characteristic of effective therapists, leading these authors to call for education to focus on personal growth and discovery of personal meaning.

A series of studies (Betz, 1962; Whithorn & Betz, 1954; 1960) of psychotherapy with clients who were diagnosed as having schizophrenia, found that the most successful therapists were more flexible with clients and formed more personal relationships with them. The less successful therapists, in contrast, were found to be distant, and either directive or to passively observe the clients. Similarly the less successful therapists shared interests with the clients that were classified as more precise and mechanistic. Competent therapists have also been described as aggressive, ambitious and outgoing (Lowinger & Dobie, 1964).

Frayn (1968) sought to assess the agreement of psychotherapy supervisors in rating the competence of residents in psychotherapy, and to assess and compare the personality of the high and low success groups. Again the findings suggest that therapists who are active, aggressive, demanding, careless and have an impulsive personality type are more effective. The less able therapists were found to have a compulsively rigid personality with a need to conform. There was high agreement amongst the supervisors (70%) as to the high ability group, while for the low ability group the agreement was not as high (52%). The theoretical orientation of the supervisor and their years of experience were not significant in predicting therapist ability. Frayn (1968) concludes that the results are consistent with other research that indicates high assertiveness and flexibility and low scores on rigidity among able psychotherapists, may prove useful in selecting residents for psychotherapy training.

3.2 THE PROCESS OF PSYCHOTHERAPY

It has been advocated (Hill & O'Grady, 1985) that process measures be used to demonstrate the differences that some professionals still believe exist in the various forms of therapy. These authors suggest that the measures used to date may not be sensitive enough, or that various treatments have different means of achieving relatively similar results. These statements are based on the considerable research that indicates that no one therapy is superior to another. Hill & O'Grady (1985) found that another field of research receiving considerable attention from researchers is that of non-specific or common factors across therapies. They suggest that the curative elements in therapy are those that exist in, or are common to all forms of treatment, rather than those that are unique to particular forms of treatment. Their work aimed to assess the process of all types of therapy by use of an "Intentions List".

Two main points need noting from their findings. First, a focus on feeling and insight were more frequently associated with psychoanalytic orientation, whereas a focus on change, setting limits and reinforcement were associated with a behavioural orientation, and a focus on therapist needs with a humanistic orientation. Second, the authors warned that as there were few "purist" therapists involved in their research, it is difficult to interpret the results. Apart from the differences noted above, there was also quite a degree of similarity in other measures used in the study. These findings support Goldfried's (1980) argument that there are commonalities among the many different treatment

methods. In Hill & O'Grady's (1985) study all therapists had similar ratings on the quality of their sessions.

3.3 THE INTERPERSONAL RELATIONSHIP BETWEEN PROFESSIONALS AND CLIENTS

Some researchers have taken the stance that, to understand therapy, the interpersonal relationship of mental health professional and client had to be studied rather than their separate characteristics (Horn-George & Anchor, 1982). In reviewing these studies, Horn-George & Anchor (1982) report that for the therapeutic outcome to be positive the client/professional relationship had to include a mutual willingness to engage in a relationship, mutual directness and mutual power. Clients' accurate perception of the values and attitudes of their therapists and similarity in the values of client and therapist were also conducive to a positive outcome.

Extensive early studies of the psychotherapeutic relationship and process (Orlinksy & Howard, 1975; 1978), found that the most useful perceptions were those of the clients. Therapists in these studies were found to have few self-perceptions and emphasise skill rather than values and affects. Attempts then to link process to outcome have been inconclusive and research has moved away from the question of its effectiveness to what factors contribute to outcome (Horn-George & Anchor, 1982).

In order to answer the later question, Horn-George & Anchor (1982) conducted a study of both short and long term therapy and professionals' and clients' perceptions over time. The results indicated a difference between long and short-term clients in how

they perceive their sessions. The long-term dyads were more phenomenologically congruent in their feelings about therapy, each other and in their perceptions of goals, than those in short-term therapy. They also found that long-term dyads had more similar affective responses to the process and course of sessions than did short-term dyads.

Earlier researchers (Beutler, 1973; Burton, 1975; Lowe, 1975; Parloff, Waskow & Wolf, 1978) have argued that mutuality and reciprocity between client and professional form the best therapeutic milieu and that professionals look for relationships in which that mutuality will occur. Likewise research has found that similarities in values, attitudes, perceptions and appearance have been shown to increase cooperation between individuals (Byrne, 1971). The findings of these researchers and of their own work have led Horn-George & Anchor (1982) to conclude that the most predictive variable of a positive therapeutic alliance is similarity in professional and client goals, and researchers are now recognising the human qualities of those who function as therapists. Further, reciprocity in the professional relationship is a possible predictor of positive outcome.

A more extensive study of the complex and important issues involving clinician-client similarity has been conducted by Landfield (1971). He notes the following important points. First, the therapist's personal characteristics are more important than the approach the therapist takes. This is because the client and therapist need to be able to identify with each other's values, be able to make sense to one another, be able to understand the other to some extent, and share a social language in order for therapy to

proceed. Second, lack of congruence between client and therapist often leads to: early termination of therapy; symptomatology more often targeted for treatment; and the use of more manipulative treatments by therapists. Third, incongruence between client and therapist will incapacitate therapists unless the therapist is able to expand their view of the client's world. Finally, Langfield notes the importance of being aware of the ethical issues that are raised when the impact of therapist's values are considered. Specifically he concludes that therapist's values must be considered whenever therapist and client are placed together.

Similarly Marmor (1988) has observed that over the years failures in therapy are not due to the orientation of the professionals, but to their personal qualifications and characteristics. The most experienced therapists who were understanding and empathic obtained the best results, regardless of theoretical orientation. However the clients' characteristics are also important. Clients need to be able to express their feelings and have trust in the professional. It is not surprising that Marmor (1988) concludes that the most important factor is the professional client relationship and that these therapeutic elements cut across the diverse approaches in psychotherapy.

The more disturbing research on the therapeutic relationship focuses on harmful therapy. Grunebaum (1986) found with a sample of professionals (who had undergone therapy themselves) that distant and impersonal therapists and those that were overly intense, were considered harmful. A further problem noted by Newbern (1987), is the problem of professionals having to continually deal with chronic mental illness. For the professionals

this often leads to stress and burn-out, with the behaviours associated with burn-out also being those associated with therapy abuse. The compounding of these feelings of stress that arises from the complexity and contradictory nature of health services, often lead to feelings of anger, frustration and powerlessness in professionals resulting in the “kick the cat” syndrome.

3.4 THE OUTCOMES OF PSYCHOTHERAPY

Studies of psychotherapy outcome in terms of professional and client variables are also relevant to my research. It is once again surprising that the studies of outcome to therapy pay little attention to professionals, some attention to clients and far more attention to other factors. Also, the research that is available tends not to address outcome of therapy for those who have more serious mental health problems. In many ways studies that address professional or client characteristics in the outcome to psychotherapy differ little from those studies that address the therapeutic relationship. Indeed the differences are subtle. I have chosen to look at them separately in order to highlight the importance and the similarity of professional and client characteristics, as well as to highlight the neglect of these variables in the literature.

Professionals who have positively influenced the outcome with clients who have been diagnosed as having schizophrenia, have been shown to be acutely sensitive, non-possessive, warm and have presented themselves as genuine real people (Truax & Carkhuff, 1963). In other studies (Frank, Gliedman, Imber, Nash & Stone, 1957; Rosenbaum, Friedlander & Kaplin, 1956) the degree of client improvement has been shown not to be related to the years of

experience of the professional. In some cases the more experienced professionals had poorer improvements with clients (Bush, Glenwick & Stephens, 1986), a finding attributed to enthusiasm in less experienced professionals and burn-out in those more experienced.

From the point of view of a person who has been treated for schizophrenia, Horne (1985) reports that the people she was able to relate to best were the inexperienced nurses who were there for a few weeks because they were “more natural” in their interactions with her. She makes a number of comments regarding her hospital experience. First, she had a great desire for someone to talk to her rather than “waiting for a rational moment”. Second, she reports controlling her symptoms in front of the inexperienced nurses who had spent the most time with her because she did not want to embarrass herself in front of them. Third, she found she could not relate to the psychiatrists as they presented as “just too wise”. The last point she makes is that nursing staff try too hard to be helpful and forget that the simplest approach is often the best.

Social support has been identified by clients as being important in treatment outcome in studies that have looked at professional and client perceptions of the treatment environment (Goldstein, Cohen, Lewis & Struening, 1988). The clients judged the programs to be most helpful when they were structured and nurturing, rather than orientated towards discussion of personal problems. However, the therapists saw the last type of program as most helpful to clients. The authors conclude that this is consistent with other studies. It also highlights the differences in what therapists think is important and what clients find helpful.

Addressing the specific rather than more general aspects of what clients wanted from their care, Lorefice & Borus (1984) found that most clients came for advice, ventilation and an understanding listener. To a lesser degree other requests included insight, problem clarification, help in gaining control and medication. At the end of therapy, the most helpful of these were problem clarification and ventilation, with problem sharing, self understanding, advice and medication also considered helpful. Less than one quarter of participants indicated that therapy helped them gain contact with reality. A third of this sample also thought that their treatment sessions could be improved, with nearly half wanting more direct advice from therapists and wanting to know their opinions. Similarly Kindelan & Kent (1987) found that patients preferred information on prognosis and diagnosis, whereas doctors perceived a greater demand for treatment information.

Rehospitalisation has also been used as an outcome measure. The best predictor of rehospitalisation for clients was the number of previous hospitalisations, while the best predictor of adjustment was the pretreatment adjustment level (Mintz, O'Brien & Luborsky, 1976). These authors found that those clients with good prognostic indices made relatively larger gains than those who did not, regardless of the type of intervention received. Other researchers (Grovesman, Nathan, Fagley & Brown, 1986) have found that their research did not appear to support recent studies that suggested hospital personnel disagree on the presence or absence of various behaviours in a psychiatric population.

3.5 DIFFERENCES BETWEEN NATURAL AND PROFESSIONAL THERAPISTS

Studies of differences between professional and non-professional therapists have been undertaken, as they have been viewed important in understanding aspects of therapeutic outcome. Toro (1986) examined the similarity and difference between natural (mutual support leaders) and professional (psychologists, social workers and lawyers) therapists. All groups were found to be equally helpful and to have many similarities. The mutual support leaders differed from the professional group only in being more self-revealing. Overall all therapists showed fewer information-gathering behaviours and more information-and-advice-giving behaviours as the helping interaction progressed.

In a study of volunteer telephone counsellors, Viney (1983b) found some differences between those counsellors whose training was professionally orientated, as opposed to those who had a nonprofessional approach. Specifically the nonprofessional group reported more anxiety and depressive feelings, but also more positive feelings, and feelings of competence than those working in the professional approach. The nonprofessionally orientated group also reported their callers to be less anxious and helpless, a finding Viney attributed to the "gut-level" spontaneity of this group and the peer relationships that appeared to be more prevalent. She concluded that training may actually be removing therapists from the world view of the client.

McCarthy & Knapp (1984) looked at the helping style of crisis interveners, psychotherapists and untrained individuals. The results indicated that the crisis interveners used a similar helping

style to telephone counsellors, that is, they were more active and directive. They were also found to be leading and problem-focused while psychotherapists were less leading, more empathic and insight-orientated. In this study the untrained helpers in contrast were described as extremely judgemental.

The success of therapy has also been addressed in the natural and professional groups. Tracey & Toro (1989) found that, regardless of therapist type, successful and less successful therapists could be identified. This study also found that clients did not respond differently to successful and less successful therapists, but they did respond differently according to therapist type. Hence, the authors concluded that the types of helping relationships established by the three groups were very different, indicating the need for more studies on different types of therapists and how they interact with their clients. However, it is important to remember that the success or failure of therapy appeared to be independent of therapist type.

3.6 THE VALUES AND PERCEPTIONS OF PROFESSIONAL THERAPISTS

In Australian mental health services, similarities and differences in the moral value systems of mental health professionals, namely psychiatrists, psychologists and social workers, have been examined by Khan & Cross (1983). These authors conclude that values are increasingly recognised as an inevitable and pervasive part of therapy affecting diagnosis, therapeutic goals, process of therapy and potentially the outcome of treatment itself. In this study the values of clients and professionals were found to be quite divergent. With regard to personal values the mental health

professionals appeared to support more active, intellectual and self-developmental values, while clients tended to support a more passive and self-maintaining orientation. Professionals also stressed a mature personal action value system with clients emphasising personal control.

Many authors have stated that conceptions of mental health and illness cannot be viewed in isolation from the problems of ethics, religion, public policy and philosophy (Smyrnios, Schultz, Smyrnios & Kirby, 1986). Further, these authors state that personal values, an essential component of human life, influence psychotherapy research and practice. These values have a pervasive influence on the type of treatment offered clients, and in therapy values often underlie the therapist's choice of treatment goals. Thus goals vary according to how the therapist interprets the changes the client seeks, and according to the therapist's own judgement as to the desirable changes. These goals, they postulate, may be different and incompatible, because therapists vary in their style and orientation as a function of both personality variables, professional background and training, which also influence choice of therapeutic techniques.

Researchers such as Lebow (1981) believe that the values of the researcher distort the effects in psychotherapy research and every effort should be made by the researcher to minimise these effects. He suggests this be done by presenting the data in an objective way and by specifying the meaning of the researchers' values in clear psychological terms. This is consistent with the earlier conclusions of Bergin (1963), who stressed the need to be explicit about the values to which professionals are committed and specify their

precise meaning and devote ourselves to developing ways of achieving these ends. The values of therapists and even of researchers are important. However I believe that they are better understood from within the framework of personal construct theory; and I hope to show this in Chapter 5.

3.6.1 Professionals' Perceptions of Good and Bad Clients

The importance of addressing professionals' values in research and in therapy is highlighted by reviewing the literature on the perceptions of good and bad clients by professionals. An extensive review of the literature of the themes that emerge in accounts of good and bad clients has been undertaken by Kelly & May (1982). They review the studies from empirical, methodological, epistemological and theoretical perspectives and find them all deficient. Their sociological study suggests that clients are defined as good and bad, not because of inherent qualities in the client, but as a consequence of the interaction between professionals and clients. In the review they report research that suggests professional ideals as imparted in training are not easily reconciled with practice. Clients are treated differently for many reasons. These range from personal, demographic and factors associated with their problems, through to the extent of available therapist skills. Similarly many of the reactions of clients to their problems are not viewed favourably. In contrast clients who are understanding, amusing, optimistic, cheerful and grateful are viewed favourably (Kelly & May, 1982). Clients who make staff feel ineffective, angry, anxious, frustrated, who attention seek or are seen as manipulative are viewed poorly.

In a final analysis, Kelly & May (1982) criticise the previous research on four grounds. Empirically, they state that the findings are contradictory and inconsistent. Methodologically, the tools used, such as fixed choice questionnaires and interviews, rather than observing the actual behaviour, could be just post hoc rationalisations of putative attitudes and behaviour. They also criticise the inadequate definition of concepts such as “anxiety” or “inappropriateness”. That is, the reader is assumed to share the same meaning for these concepts. Also there are taken-for-granted notions like “good” and “bad”.

From an epistemological viewpoint, Kelly & May (1982) attack previous research because the focus of the research on individuals leaves out an account of the social structure and social process. They propose an alternate framework that views professional roles from an interactionist perspective. This interactionist viewpoint has also been suggested by McGoven, Newman & Kopta (1986). In a report on the situational versus personalistic debate about determinants of behaviour, they conclude that a compromise has to be reached about the determinants of behaviour. This is reasonable given the work of others (Wills, 1978), who claim that the negative bias of professionals’ attributions has an impact on clinical judgements and practice. Similarly Brickman et al. (1982) make the distinction between attribution of responsibility for cause of disorders and attribution of responsibility for their solution. These authors hypothesize that a professional's model of responsibility is a metatheoretical assumption that complements or supersedes his or her school of psychotherapy. These assumptions about responsibility for the problem cause and its remediation, manifest themselves in diagnosis of the problem, the type of

intervention chosen, goals, choice of and amount of treatment, and the expected roles of the client and therapist (McGoven et al., 1986).

Professional attitudes to the chronically mentally ill (CMI) have not been shown to be favourable. Psychiatrists, social workers, nurses and allied health staff reported 85% moderate to strong agreement that the CMI were not the preferred client population to work with; 63% felt there were no satisfying professional rewards working with them; 68% felt most professionals did not get adequate training to work with them; and 90% felt that current services were inadequate and there was a serious lack of effective integration of services (Mirabi, Weinman, Magnetti & Keppler, 1985). Given the changes taking place in mental health service provision such findings are important.

3.6.2 Professionals' Perceptions of Difficult Clients

Another area of study of the attitudes of professionals has been with difficult clients. and these have been studied across different professions. Colson et al., (1986) report that professionals respond to clients in different ways, depending on their own affiliations, professional identity, specific role in treatment and the nature or extent of their relationship with clients. In their study they found distinct differences in emotional reactions between professions. However, they interpreted this in terms of the different amount of contact each profession had with the clients as the most important variable. Yet there was a great deal of anger and helplessness in all professions.

In other studies with difficult clients (Robbins, Beck, Mueller & Mizener, 1988) the authors have concluded that professionals may consider neuroleptics the only promising intervention for those who are not suitable for psychotherapy. From their conclusions an important point can be drawn. That is, we need to go beyond looking at what constitutes difficult clients and turn to understanding why therapists make these designations. Others (Steinberg & Hughes, 1987) have noted that professionals, when working with difficult clients become more concerned about the clarity and nature of their work than with the clients themselves. These authors advocate looking more closely at organisational variables as difficulty with clients may in fact reflect difficulty with their job.

Other studies of the patterns of professionals' perception of difficult long-term psychiatric clients (Colson et al., 1985) found there were no unique determinants of difficult clients in spite of profession or length of clinical experience. Generally difficult clients were those perceived as improving less. Once again an important factor was found to be the therapeutic alliance between client and professional (Colson et al., 1985).

3.6.3 Perceptions of Professionals in Contrast to those of their Clients and their Families.

Studies are also beginning to appear focused on the discrepancies between professional and family attitudes to treatment. In a large study by Bernheim & Switalski (1988), they found that the professionals had a good attitude to families but that the type of involvement was less than desirable, professionals citing conflict among themselves about the role of the family and lack of time as

major problems. The families, while finding the professionals supportive, reported receiving little of what they needed.

Clients and professionals have been shown to share common views concerning the source of the clients' crisis, the problems to be addressed during hospitalisation and also generally agreed with assessment of treatment and outcome (Harper, Elliot-Harper & Weinerman, 1982). However, in this study clients were found to be more optimistic concerning their condition on discharge and the efficacy of the treatment than were their therapists. There was no difference found between those clients who agreed with their therapists and those who did not, in attaining the treatment goals.

The difference between professional and client attitudes and treatment expectancies has also been found in the treatment of alcohol abuse. Potamianos, Gorman & Peters (1985) found that doctors and nurses had similar scores indicating a psychological approach to treatment, but that clients were significantly different, favouring an organic approach to treatment. In other studies (O'Donohue, Fisher, Plaud & Link, 1989) clients have appeared to rate the decisions made by their professionals based on more informal experience just as favourably as decisions made on more formal grounds. It has also been found that professionals prefer longer treatment duration than clients and that clients are more likely to dropout of therapy due to a dislike of therapy, or the professional, than is expected by therapists (Pekarik & Finney-Owen, 1987).

Lefley (1985) also reviewed the research on professional and client perceptions that indicates service needs and priorities differ vastly from those of most health professionals and families. Such reports

must raise questions about what professionals do in their work and how they make sense of their involvement with clients if they are not meeting the clients' needs.

3.6.4 The Changing Attitudes of Psychiatrists

There are many studies that report on psychiatrists' changing attitudes to aetiology and treatment over time. Psychiatrists as a group appear to have united and determined their unique speciality. A longitudinal study of psychiatric residents over a ten year period (Coryell, 1987) found progressively less antagonism to the medical model amongst the group. Earlier studies (Engel, 1972; Greden & Casariego, 1975) had reported hostility in this group to the medical model. Coryell (1987) states the shift is probably due to the increased competition with psychiatrists from non-physician psychotherapists. This competition is forcing psychiatrists to emphasise their uniqueness by focussing on diagnosis and biological treatment. At the same time, psychiatry is becoming more biological due to pharmacotherapy, operationally defined diagnosis and new biological probes. This article supports the increasing medical base to psychiatry. Coryell (1987) also reports that psychiatrists are more optimistic about the medical/biological treatment options and now more open to them.

Similar results (Gallagher, Jones & Barakat, 1987) have been found with practicing psychiatrists who predominantly support a biological causation for schizophrenia, distinct from ten years ago when there was no particular preference for a biological or environmental origin. Professional characteristics such as years of experience, treatment setting and school of thought were no longer significant factors in determining their attitudes. However there

appears to be a preference for a combination view, that is, environmental factors could trigger schizophrenia in a biologically predisposed person. How then does this influence their relationship with clients? Andrews, Vaughan, Harvey & Andrews (1986), in a survey of Australian psychiatrists, found antipsychotic medication in conjunction with either supportive psychotherapy or family/social interventions were recommended by nearly all psychiatrists for the treatment of schizophrenia. Another interesting finding was a reluctance for them to treat people suffering chronic schizophrenia. These people are usually the most difficult to treat and constitute a high proportion of clients referred to multidisciplinary settings.

In terms of this thesis, this finding is interesting, because what were reported as earlier attitudes have been changed over time predominantly by belonging to a certain group whose education is changing. I suggest this is due to the need for specialisation that has resulted from the influx of other professions. So what were once shared attitudes amongst different professions to treatment in psychiatric settings, are now becoming quite separate for each profession. Similarly, the question of who should provide services to clients, and what these should be is raised. This is at a time when a multidisciplinary approach to psychiatric/mental health care is being increasingly advocated. It would seem reasonable to assume this must create conflict in some way within these teams.

However, when the views of practicing psychiatrists were evaluated on the treatment of anxiety and somatoform disorders, no agreement could be found other than for obsessive-compulsive disorder (Andrews, Hadzi-Pavlovic, Christensen & Mattick, 1987).

In this research, in no disorder did more than one third agree about treatment, and this was for the obsessive-compulsive group. It would appear that the apparent agreement of psychiatrists exists only for the more severe mental health problems for which multidisciplinary teams are most likely to be deployed.

3.6.5 Attitudes to Treatment and Aetiology Amongst Mental Health Professionals

A natural progression from studies that address the differences between professionals and client perceptions is to study those professionals who have a family member with a mental illness. Lefley (1985) undertook such a study with social workers, psychologists and psychiatrists and found they favoured a biogenic aetiological model of causation over a faulty family relations model. Specifically she found that change occurred for 75% in their theoretical orientation, 84% in their ideas of aetiology, 91% in their ideas of treatment and 84% on their ideas of prevention, as a result of having a family member with a mental illness. All these responses were at the “great deal” end of the scale used in the study. These results do however raise the question of the coping mechanisms of these participants. It is well known that the disease model of illness is favoured by clients as it abdicates responsibility for those concerned.

The clinical judgement, diagnosis and selection of treatment of different mental health professionals has been studied by Turner & Kofoed (1984). They state it is often assumed that differences in these reflect differences in training, experience, professional or program affiliation. Their research shows that professionals’ response styles have been highly individual and contain biases. In

their study these authors attempted to see if the latter could be related to profession, work setting or program affiliation. The results indicate that profession, work setting or program affiliation could not predict a bias in mental health professionals' decision-making. Rather it appeared that members of the same profession, work setting or program affiliation were just as likely to disagree with each other. Mental health professionals also displayed no greater consensus in decision-making than para-professionals.

Turner & Kofoed (1984) consider that their research supports earlier work (Baxter, Chodorkoff & Underhill, 1968; Gauron & Dickinson, 1966; Kendell, 1973; Sandifer, Hodern & Green, 1970) indicating that information that contributes most significantly to clinical decision making is limited and that various professions, including para-professionals, perform similarly. They suggest that the results have interesting implications for the team approach and suggest that team decision-making may be helpful in broadening the types of information and treatment alternatives considered. Also the essential element of an effective decision-making team may simply be a number of individuals with varied sensitivities, biases or sets toward client problems and treatment alternatives. The conclusion they draw from their work is that the current emphasis on profession as a determinant of team composition may be unnecessary and ineffective. They advocate more attention to representing a diversity of ideas and opinions when a clinical team is being assembled.

3.7 PROFESSIONAL ATTITUDES AND THE ESTABLISHMENT OF NEW SERVICES

So far I have presented quite a divergent number of factors that influence professional attitudes. There should be little doubt from this that professional attitudes are important when establishing new services, particularly given the major shifts that have taken place in the mental health field. As mentioned earlier there has been a significant move from custodial care, to far more liberal community intervention strategies. As early as 1962 Cohen & Struening noted that the friction found between professional groups in hospitals was a manifestation of widely separate views of the nature and progress of the more serious mental health problems held by different professional groups. This is a theme found throughout the literature: that professional attitudes are important because they have helped to make innovative ideas difficult to implement.

Winter et al., (1987) in their study of a psychiatric crisis intervention service reported on the difficulty in establishing new treatment interventions. The resistance to such services led the authors to explore professional and client attitudes to psychiatric treatment. They found that the professionals' attitudes to treatment reflected their more fundamental constructions of the world, that is their personal styles. This work replicated the findings of Caine, Wijesinghe & Winter (1981) and Caine, Smail, Wijesinghe & Winter (1982). Winter et al. (1987) also noted the differences between professional groups on how they viewed the more serious mental health problems, that is, in terms of psychosocial or illness contexts. The authors have suggested that:

"group differences of this order would suggest that interdisciplinary conflicts, ostensibly focusing on clinical issues, may in fact reflect divergences in more basic assumptions, values, and social and political attitudes" (p. 237).

Given the greater emphasis placed on the multidisciplinary approach to care in psychiatric and mental health settings which has occurred due to the complexity of such disorders, these findings are of concern. It appears that different professions construe the more serious mental health problems in different ways and this difference in approach is creating conflict in service delivery. It is ironic that this occurs with mentally ill clients who are probably the most vulnerable of all mental health clients, because of the difficulties they face in construing reality. Such differences in professional attitudes must have an impact on therapeutic outcome.

3.8 SUMMARY

In this chapter I have focused on the importance of understanding professional attitudes in relation to many aspects of mental health services. I have argued that it is important to understand the meaning that professionals attribute to their work, that agreement between client and professional is important, as are the professionals characteristics. I agree with Bannister (1985) and Viney (1983b) that professionals need to be able to enter the personal world of their clients for their interventions to be successful. This makes professionals vulnerable to viewing themselves as similar to their clients and therefore may cause them to hesitate in looking at themselves and their values in the therapeutic relationship (Fransella, 1983).

Changes in mental health services over the decades have similarly challenged the attitudes and values of some professionals. It could be the divergence between their own and the service's new ideals that also contributes to burn-out in professionals. I have addressed how burn-out in professionals can be harmful to clients and suggest that professionals need to start reporting difficulties they may have in adjusting to the establishment of new services. Similarly they also need to state what their values are when they undertake research. This requirement I shall meet in Chapter 7 of this thesis.

Another important issue that has been raised in this chapter is the training of mental health professionals. Training may be contributing to removing us from our clients' world view. Values and perceptions have been noted to be different between client and professional, and it is logical that training may be an important variable in this. Similarly there is little doubt that there are differences in what professionals think are important and what clients find helpful. If the type of therapy is not the important factor in success and the type of professional is, how does training impact on this? Also attitudes in psychiatry appear to be changing as a result of "market forces". I suggest that this is because psychiatry is more advanced as a profession than the other mental health professions and therefore more able to be unified in their response to these "forces". Training is also a relevant issue, although there also appears to be sufficient evidence to suggest that professions may be more similar than different in their work with clients. The next chapter is devoted to exploring the many issues involved in training of mental health professionals.

CHAPTER FOUR

PROFESSIONAL TRAINING

The training of mental health professionals has been identified as the major reason why the new approaches to mental health have failed to be implemented (Glick et al., 1989). This may be due to the difficulty in training professionals when the biases to treatment vary markedly, both within and between trainers, trainees and even society. The proposed strategy to gain better training, put forward by Glick et al. (1989), is to provide a wider range of experiences for trainees so they can incorporate these new treatment modalities into their work. Such a proposal is based on many assumptions that may or may not be correct.

Runkel & Damrin (1961) argue that training should be liberating, providing trainees with an enhanced repertoire of criteria to guide their judgement. This is in comparison to untrained people whose responses are determined primarily by the situation. Training is proposed to provide knowledge that gives the professional many ways of discriminating the situation. However the role of training in forming the perceptions of professionals is complex and has been little studied. First, many projects start with the viewpoint that each profession will vary from the others, without first establishing if this is true. This is important because, as I have previously stated, the members of different professions may have far more in common than we choose to acknowledge. Second, the members of these professions, it appears, are reluctant to look at themselves and the role that their thoughts and feelings play in the treatment process.

The claims for training that have been made are based on the assumption that training can, and does, change people's fundamental beliefs about mental health problems and their

treatment. It is the purpose of this chapter to examine this assumption for the various mental health professions during the training process. The chapter deals specifically with what appear to be four major themes in the literature that refer to differences between mental health professional groups. These differences can be due to various aspects of the training process, to professional attitudes or both factors. The first difference is in the nature of science for each profession. The second consists of the impact of professionalisation on these different groups. The third concerns both the clinical and theoretical parts of training programs. The fourth deals with professional attitudes and the personality factors of different professional groups.

At this point it is important to point out that most of the available literature on professional attitudes in the field of mental health is based on questionnaire data. The limitations of this type of data must be acknowledged because of the predetermined meanings of questionnaires (Viney, 1987); however they provide some important information that merits presentation. The major themes in this research literature on training will now be discussed.

4.1 TRAINING AND PROFESSIONAL ATTITUDES

4.1.1 The Assumptions of Science

Kingsbury (1987) has argued that the cognitive differences between psychologists and psychiatrists are due to the fact that neither profession shares the shaping experience of the other, and may therefore misunderstand the emergent differences. Both disciplines conduct psychotherapy and, as research does not report either profession to be superior in this endeavour, the

common assumption to account for the rivalry that exists between these two professions is that differences are due to power struggles. However as Kingsbury (1987) points out this is only a part of the issue as the assumptions of science, thought and the clinical experience for each profession are different. It may be argued that nurses are similar to psychiatrists in their assumptions about science, and that Kingsbury's point about psychiatrists and psychologists has relevance for the nursing profession as well.

Kingsbury (1987) maintains that psychologists view science as a method of inquiry with facts less important than the developing theories that guide thinking. In contrast, medical science is viewed as a set of facts, a body of knowledge and procedures, with literature reviews providing facts with no space for how they were derived. In this paradigm, science teaches a logical method for approaching cases, making it easy in emergency cases for example, to act immediately and contemplate and critique performance later. Kingsbury(1987) further states that the medical model is no more than a method of data collection in which the presence of disease is not even necessary; rather it allows for differential diagnosis which implies cause and hence treatment. These factors he states lead psychologists to view psychiatrists as being very narrow in their approach, while psychiatrists tend to view psychologists as refusing to adopt a more rational approach.

Another important difference for these professions is their clinical experience (Kingsbury, 1987). Psychologists use clinical experience to reinforce learning about theories. The clinical experience per se is not the major focus of training. However in the medical profession clinical experience is primary, where findings or facts

can be uncovered, and it was very important that these facts are not missed. An interesting stereotype he refers to is “the psychologist lost in thought” and “the psychiatrist lost in action”. Hence from Kingsbury’s work, the differences in attitudes between the professions is seen to be a direct result of both theoretical and practical training that are based on the different assumptions about the nature of science.

The fact remains that psychiatrists know little of what psychologists do, creating conflict in the striving for equity between at least these two professions. Yet research indicates that this lack of understanding is more widespread than just discrepancies between psychologists and psychiatrists. In a study of emergency personnel treating clients who had attempted suicide (Suokas & Lonnqvist, 1989), it is interesting to note that although all professional groups had the same negative attitude to attempted suicide clients, it was only the medical profession who believed they were adequately trained to treat these people. Kingsbury's comments on medical training provide some insight into how doctors come to make these assumptions, which of course must be questioned.

4.1.2 Professionalisation and Training

Professionalisation is another important factor in understanding the differences that exist between professional groups. One of the main influences of professionalisation is the use of power by the more advanced professions to control those who are less advanced (Tooth, 1984). This in effect mitigates against the close working alliance needed in mental health service provision. For example, professions such as nursing and psychology are said to have a

natural alliance, as the two professions share many common interests and problems, yet they are reluctant to work together (DeLeon, Kjervik, Kraut & VanderBos, 1985). According to these authors the main reason for this is best understood at the educational level, because nursing has only more recently begun university level qualifications. There is also a fundamental lack of understanding and respect for each others' professional skills and scientific knowledge base. Other reasons put forward are: the difference in the allocation of research money; the academic structure traditionally not affording cross-fertilisation; interprofessional competition for the shrinking mental health resources; and that, for nurse practitioners, as nursing has historically deferred to the medical profession, this invitation would represent the forces which they have been struggling against for years. The authors conclude that, whatever the reason, it is a luxury that neither profession can afford any longer. I believe that their argument could apply equally to all of the mental health professions.

4.1.3 Clinical and Theoretical Training

In the clinical setting research has addressed the most effective way of changing professional attitudes to different treatment approaches. The role of both clinical and theoretical training in relation to professional attitude change has also been addressed. For example, the provision of information about mental illness and psychotherapy on their own have been shown not to be enough to change the attitudes of nurses to mental health problems, but change has been found when it also included practical experience (Altrocchi & Eisdorfer, 1961). Authoritarian and social restrictive

attitudes have also been found to decrease following clinical experience (Gelfand & Ullmann, 1961). Similarly Creech (1977) found attitudes to change in a favourable direction following nurses' hospital placement in a psychiatric treatment setting.

The literature appears to support the notion that short-training courses for professionals can have a positive influence on attitudes (Flowers & Booraem, 1989; Hagerty & Abraham, 1982; Pecora, Delewski, Booth, Haapala & Kinney, 1985). Current training also needs improvement. Hagerty & Abraham (1982) argue that in-service training must be clinically relevant, meaningful and not just provided to meet the need of administrators. They also concluded that educators need to provide more highly individualised learning experiences.

Slimmer, Wendt & Martinkus (1990) have studied the effect of the site of the clinical experience on change in attitudes toward the more serious mental health problems in psychiatric nursing students and found no significant differences. However while not changing their attitudes, they did perceive a significant difference in the treatment orientation of the two sites and the students in the centre that was less therapeutic and supportive, viewed the psychotherapeutic ideology more negatively. The authors attribute this finding to nursing staff not being supportive of the students' learning experience. They concluded that it is necessary to provide exemplary role models to affect attitude development in students.

Training programs designed to emphasise the interdisciplinary process have been established, due to the increasing awareness by educators of the need to be concerned with the attitudes of their students, although this has been increasingly difficult to assess

(Small, 1975). Moffic, Blattstein, Rosenberg, Adams & Chacko (1983), examined a program established to promote interdisciplinary functioning in teams of different professions (social workers and psychiatric registrars). Attitude changes were measured over a three year period and these two groups were compared with the interdisciplinary faculty members, clinic para-professionals and more junior residents. They found first, second and third year social workers consistently more enthusiastic about interdisciplinary training, with the first year residents having the least interest. The social work students also had a greater preference for interdisciplinary team-work than psychiatric residents and were the only group to change their attitudes about some forms of intervention.

Moffic et al. (1983) noted that the faculty members also differed in their response to questions on intervention in a similar way to the students. That is, social work faculty members were more positive to psychotherapeutic approaches and the medical faculty members less so. These findings indicated to the authors that the attitudes of the faculty appear to be a crucial factor in training professionals and they conclude that educators need to examine not only their training programs, but their own conscious and unconscious attitudes and values. This is necessary in order to determine what kinds of changes are important and what sort of role models there ought to be in providing comprehensive community mental health care.

Indeed multidisciplinary training better prepares professionals to work together harmoniously and provides a common body of knowledge (Smith, 1974). In some services like the Menninger

School of Psychiatry it is accepted practice (Modlin, 1983). However the problems with multidisciplinary training are well documented (Bates-Smith & Tsukuda, 1984). To overcome them, these authors state that members must have a common core of knowledge introduced and different professional values must be clarified. A problem that does arise is that of role expectations that often lead to questions of professional identity. I believe that this is one of the central problems of multidisciplinary teams. Also there are problems of professional allegiance that arise. It does appear that some people within professions are not suited to these new roles (MacDougall & Elahi, 1974; Pinkerton, Moorman & Rockwell, 1987) and that multidisciplinary training should be introduced earlier rather than later in training. Pinkerton, Moorman & Rockwell (1987) conclude that few question if multidisciplinary training works, but that the question arises as to how it works. They state that to be successful, commitment is needed from senior staff who have positive attitudes and that these staff need to be good role models.

Many other potentially important factors in training have been identified. The time of initial training has been shown to be important in the philosophy psychologists adopt in regard to clinical practice and to the specific clientele and procedures that characterise their professional activities (Cohen & Holstein, 1982). Suokas & Lonnqvist (1989) also suggest that professional education, provision of supervision and changes in working conditions are necessary to improve attitudes and hence quality of care. Weinman & Medlik (1985) indicate that medical education can play an important role in determining doctors' views of the nature of disease and their role in caring for their clients. Roskin &

Marell (1988) review numerous studies that indicate attitudes can be changed by an appropriate amount of training and clinical experience. In their own study they found that psychiatry residents scored the highest on the psychological nurturant-empathic approach and surgical residents the lowest. They suggest that certain training programs may be affecting attitudes in a counter productive way and that there is a need for more in-depth personality and psychological profiles of professionals.

Another aspect of the debate regarding the similarities and differences that exist between mental health professions is the fact that not all training programs for each discipline have the same theoretical orientation, or provide similar clinical experience. In America the attitudes of psychologists to the type of post-graduate training undertaken, that is either the traditional PhD or the PsycD, has received attention. Peterson, Eaton, Levine & Snapp (1982) found that the theoretical orientation varied considerably from one school to another and generally the attitudes of the psychologists to their own post-graduate training were better for the more practically orientated PsycD.

Within the mental health nursing profession, nurses are starting to acknowledge the inadequacy of their basic training for the roles they are now called upon to perform (Reavley & Herdman, 1985). This is understandable, as mental health nursing was originally developed at a time when nurses were asked to be little more than custodial care-givers.

4.1.4 Professional Attitudes and Personality Factors

The next major theme, in the literature on similarities and differences within and between professions, is professional attitudes and their personalities. An extensive examination of the difference between psychologists, social workers and nurses on attitudes to treatment and aetiology of mental disorder has been undertaken by Roskin, Carsen, Rabiner & Marell (1988). This review indicated that many medical students went into psychiatry with a psychodynamic framework but came out with a significantly biologic-organic one. Female students were also found to be more psychodynamic than men. They also report studies that show attitudes can be changed by an appropriate combination of clinical experience and didactic training. A major problem with these studies cited by the authors is the lack of reliable instruments to measure attitudes to clients and their study's main aim was to fill this gap.

The authors noted that the differences in attitudes make for diversity in clinical care and this can be helpful to service provision. They also believe that the observed differences in approaches is due to who is attracted to each of the professions, as well as to the nature of training/experience each profession receives. Their conclusion was that the results can be accounted for by personality characteristics of individuals in a given profession on the one hand, and training and clinical experience on the other. They suggest that the fundamental paradigms/models of which professionals are often unaware, attract certain types of individuals. Also there may be multiple models within a given field and these may be in conflict. The use of several models is thought

to have a significant impact on client care, as the treatment afforded clients will be different according to the model chosen. At the same time, these conflicting paradigms provide advantages for client care and expanding knowledge in the field. However no evidence has yet been provided on whether these changes have been long term.

The change in psychiatrists' attitudes to aetiological theories of schizophrenia has already been addressed in Chapter Three and will only briefly be presented here for the sake of completeness. Gallagher et al. (1987) found in 1975 there was no particular preference for environmental or biogenic explanations, however there was a general feeling that environmental factors were more strongly related to the origin of mental health problems. In 1985 this was no longer true, with psychiatrists predominantly supporting biogenic theories. When they were questioned further, a preference for a combination view was found. Specifically environmental factors were more likely to trigger schizophrenia in a person who was biologically predisposed. In these studies characteristics such as years of experience, treatment setting or school of thought were significant variables influencing psychiatrists' viewpoints in earlier studies, but not in the later studies. This is supported by other studies (Chinnayya, et al., 1990; Cohen & Struening, 1962; Middleton, 1953) that show age, gender, IQ, education, or years of experience could not be relied on as predictors of staff attitudes.

In the 1950's authoritarian attitudes, especially at the bottom end of the work-force were found. Theorists such as Gilbert and Levinson (1957a, 1957b) considered attitudes to be on a

continuum from humanism to custodialism. In their opinion the humanists saw the hospital as therapeutic and emphasised interpersonal and intra-psychic aetiology, viewed the clients more in psychological terms than moral ones, were optimistic about treatment and sought to democratise the hospital. However hospital staff were reported to be pessimistic, impersonal and mistrusting of clients, considered mental illness a moral flaw and wanted to keep the hospital in its traditional form.

As Brown (1986) rightfully points out, the question of causality has to be raised at a very early stage of service development, because service policy is correlated with professional ideology. That is, it is possible that staff attitudes are not pre-existing entities but occur as a result of the historical legacy of the custodial asylum. Wagenfeld, Robin & Jones (1974) note that this is an old question that has much precedent in social science and health research and raises this question: Are mental health workers socialised to an ideology through the organisation, or is the organisation influenced by the ideologies of the staff who arrive there either by self selection or happenstance?

Studies of attitudes to client rights have been raised independently of the development of the psychiatric profession. Yet this pro-biology development may influence psychiatrists to hold beliefs more cautious and even antagonistic to the liberal beliefs of the community mental health era (Brown, 1986). In his study Brown (1986) found that there were few differences between professional groups on attitudes to client rights. He believes nursing staff are becoming more liberal and the psychiatrists more conservative. This is consistent with the findings of Cohen & Struening (1962)

two decades earlier who reported psychiatrists to be the most conservative in social restrictiveness; and Baker & Schulberg (1967) and Wagenfield et al. (1974) who found psychiatrists to have very conservative mental health attitudes.

The fact that the results of a study by Perry (1982) show psychiatrists to be the most opposed to client rights, which is contrary to earlier research, is at least evidence for the argument that psychiatric conservatism plays a major role in equalising staff attitudes (Brown, 1986). The finding that psychiatrists no longer exhibited liberal attitudes concerning mental health may be because the early years of innovative theory were giving way to the difficulties of implementation and psychiatrists no longer had the option of such progressive views (Brown, 1986). Brown (1986) concludes that psychiatry is continually moving closer to the strict medical model, partly because of the success of the psycho-active drugs but also because the practitioners are seeking the respect, privilege and power accorded to other physicians. He believes this is supported by the shift of psychiatric services to general hospitals. However it must be remembered that the shift in services is also an ideological one consistent with normalisation theory.

In order to understand the different assumptions made by the different members of the same profession, Krasner & Houts (1984) looked at two groups of psychologists in terms of their basic assumptions about psychology and science. They suggest however that the differences that exist may not extend beyond discipline-specific assumptions. That is, they found systematic differences between their political, social and philosophical values. They

suggest that broad, culturally determined values can be compatible with different profession-specific assumptions, and that it is possible that behavioural scientists select and value different assumptions about their profession, and that these choices are unrelated to their stands on broader value issues. This is consistent with the work of Winter et al. (1987).

Krasner & Houts (1984) conclude that if psychology as a science is not value free, then it is necessary to systematically investigate the relationship between the values of psychologists and their research. This suggestion fits with the work by Winter et al. (1987) who showed that the approach to treatment reflected the individuals more general attitude to life. These attitudes it is assumed reflect the individual's central constructions of the world and as such would be very difficult to change. The work of Winter and his colleagues is important in understanding the similarities and differences within and between professions and will be expanded on later.

Other authors have stated that conceptions of mental health and illness cannot be viewed in isolation from the problems of ethics, religion, public policy and philosophy (Smyrnios, Schultz, Smyrnios & Kirby, 1986). Further, these authors argue that personal values, an essential component of human life, influence psychotherapy research and practice. These values have a pervasive influence on the type of treatment offered clients and in therapy values often reflect the professional's choice of treatment goals. These goals vary according to how the professional interprets the changes the client seeks and according to the therapists' own judgement as to the desirable changes. In essence

then these goals may be different and incompatible. Professionals vary in their style and orientation as a function of personality variables, professional background and training, and these factors also influence their choice of therapeutic techniques.

Indeed the influence of a professionals' attributions in determining how they interact with clients and determine treatment, has received attention from a few authors (Brickman et al., 1982; McGovern et al., 1986; Wills, 1978). All conclude that the professionals' attributions either complement or supersede their professional training.

Research, like professional practice, is influenced by the researcher values. To minimise their influence, presenting data in an objective way and specifying the meaning of the researchers' values in clear psychological terms have been suggested (Lebow, 1981). This is consistent with the earlier conclusions of Bergin (1963), who stressed the need for researchers to be explicit about the values to which they are committed, specify their precise meaning and devote themselves to developing ways of achieving these ends. The comments made by these authors seem to me to apply equally well to the training of mental health professionals, as well as to treatment implementation by professionals.

4.2 SUMMARY

The recurrent themes in the research that have been described in this chapter on professional training are: the importance of role models in each professional's development and that clinical experience is crucial in shaping attitudes. We also need to pay more attention to training because more questions appeared to be

raised than answered about the attributes of the professionals and the professions to which they belong. The relationships between training and personality factors are interwoven and complex. The professions that are more “professionalised” than others appear to be “closing ranks” as a result of the threat experienced by them from the changes in the mental health system. Finally, there appears to be strong empirical evidence for the role of personal values in the practice of both the professional and the researcher.

In the beginning of this chapter I began by saying that training has been put forward as one of the main reasons why new approaches to mental health have failed to be implemented. This was said to be due to the diversity within and between professions that leads to biases which supposedly can be corrected by wide experience and interdisciplinary training. Yet other research indicates that years of experience is not a reliable variable in predicting attitude change. Others claim that attitudes can be changed by training, while others say we choose those aspects of our training that are consistent with our original world view.

There appears no guarantee that even training in one profession will deliver the same professional values to everyone. The complexity of the issue of training in relation to values, attitudes or perceptions has been demonstrated. I have also identified four themes in the literature that support a general view of similarity within and difference between professions. This underlying assumption that professionals in each profession will be similar in some way yet different from the others, is an important one that formed the basis for the questioning guiding this research. Certainly there is a need to have a theory that is capable of making

sense of all this research that at times appears contradictory. It is also important to have a theory that will encourage more exploratory methodology to gain new insights into this complex issue. I have also noted that the almost exclusive use of questionnaires has limited past research.

In the next chapter I shall argue for the usefulness of personal construct theory in providing an overall theoretical framework for guiding my research on mental health professionals' constructions of their clients.

CHAPTER FIVE

A PERSONAL CONSTRUCT THEORETICAL APPROACH TO PROFESSIONAL-CLIENT RELATIONSHIPS AND MENTAL HEALTH SERVICE DELIVERY

In the previous chapters I have presented research that is both complex and has some contradictory findings. What has been lacking in much of the research is a theoretical framework to guide the research. What I aim to achieve in this chapter is to provide an integrating conceptual framework for understanding the plethora of results presented so far and for my own research. I have chosen personal construct theory (Kelly, 1955) for this purpose. As I present the theory I shall show how it provides this integrating conceptual framework.

I shall first provide an introduction to this theory, then an account of the personal construct theory model of mental health service organisation proposed by Winter (1985c). I show how this model can be extended to embrace the many variables in the complex issue of mental health service provision. In doing so, given my aim of understanding how different mental health professionals make sense of what they do when they work with clients, I provide a starting point for my own theory-guided research. I shall also present other research conducted in relation to mental health service provision that has used personal construct theory.

The data collection and analysis of my research will also use the methodologies consistent with this personal construct theory orientation. Kelly (1955) recommended asking clients or research participants the questions for which answers were required, rather than trying to elicit these answers indirectly. This is the spirit in which this research will be conducted. My starting point of exploring how different professionals understand their work with clients has been chosen because it is the first question that I, the researcher, want answered in my own search for meaning in the

mental health field. I shall expand on this approach to research throughout this and my next chapter. Many factors involved in mental health service provision can be explored from within this framework. In time such explanations will determine the theory's usefulness.

5.1 PERSONAL CONSTRUCT THEORY

The following summary of personal construct theory is taken from Kelly's (1955) major work. All people are considered as scientists. That is, they are scientists in the sense that they all seek to predict and control their worlds, using prior beliefs derived from their experiences that continue to change over time. What psychologists then have traditionally called the personality, a rather static entity, Kelly saw as best understood in terms of the way people experiment with their worlds given their predictions. They do not simply respond to their worlds but make representations of it. These representations can change, as well as be different for different people.

These notions are based on Kelly's central assumption of constructive alternativism. People construe their world based on their predictions, but they are also free to place alternate constructions on their world if those that they have made do not work for them. Phenomena in this sense may be misrepresented, but they are still real for the person who has construed them. Constructs are ways of construing the world that enable a person to plan their behaviour. In essence they form patterns that the person creates to understand their composition of the world, and the fit of these patterns to their world may not always be good. If the fit is not good they seek to increase their repertoire of

constructs so that a better fit may be obtained. Constructs are not only used to forecast events but also to assess the accuracy of the forecasting afterwards. Constructs function within a system of constructs, with some constructs being more central than others. The more peripheral constructs are more easily modified.

Any change within the subordinate constructs that threatens those constructs that are more central to the person is likely to be given up by them, even if it is more adaptive. This is because of the investment people have in these more central constructs. It frequently takes life-shattering experiences to force people to change their more central constructions of the world. Therefore constructs that are used to predict immediate events are most likely to change because they can be immediately validated. When this validation is less quickly available, then change within the construct system is likely to be slower. Also people's hesitation to try out new constructs is due to their fear that the conclusion will lead to ambiguity, a situation where they are no longer able to predict and control their worlds, also, constructive alternativism "assumes that all our present interpretations of the universe are subject to revision or replacement" (1955, p. 15).

At the same time people are able to contain certain facts or knowledge within parts of their construct systems that may be shared with others. This sharing of constructs, enables them to limit their construing of events or ignore them as they are seen outside their realm of experience. This, then, enables professionals to contain their specialist knowledge within a construct system that may be shared with other members of the same profession. The concept of constructive alternativism can account for why

professionals choose to adhere to one theory as opposed to another and why they choose certain therapeutic techniques and research methods in their work. This is so because the predictions of each professional would be based on the specialist knowledge that they have. Members of the same profession would be expected to choose those therapeutic techniques and research methods consistent with their specialist field. However, it is becoming increasingly clear that there is much overlap between the various specialist fields of knowledge.

Kelly has described the range of convenience of people's construct system. That is, people can only understand those facts that are within their range of convenience and not understand those facts outside their systems of constructs. People may share their constructions of either of the mental and physical realms with those who have similar training, but sharing their constructions with those who are not similarly trained may be beyond their range of convenience. Yet many facts may be equally well construed within either construct system. "Facts", then, are really in the public domain and may be simultaneously construed by members of many professions. The difference between professions is because there is no unified construct system that all professions share. For the time being then, professionals will have to be content with a series of smaller construct systems that have limited ranges of convenience, but be aware that any event may be construed within any of these smaller systems. Following from this it seems reasonable to assume similarity of constructions within members of the same profession, with differences occurring between professions due to this limited range of convenience of the construct systems of the professionals.

The concept of the range of convenience of people's construing is fundamental to understanding some of the confusion that currently arises amongst different mental health professionals in their attempts to work together.

Personal construct theory consists of a set of principles that bind together psychological events that enable their immediate comprehension. The basic assumption, or fundamental postulate, on which the theory is based, is: "a person's processes are psychologically channelized by the ways in which he anticipates events" (Kelly, 1955, p. 46). This postulate is elaborated by eleven corollaries, all of which are relevant to my research.

5.1.1 The Construction Corollary

I have touched on the first corollary, the Construction Corollary, which states that people anticipate events by construing their replications. People place an interpretation on what is construed within a structure that allows the assumption of meaning. In the process of construing, people erect constructs of similarity and contrast. That is, each construct provides choices. Also in the replication of the process of construing, recurrent perceived themes help people to make sense of their experience and help establish for the person the bases for likeness and differences. This allows people to also predict future events based on past similar ones. This process may allow mental health professionals to make diagnoses about their clients.

5.1.2 The Individuality Corollary

The Individuality Corollary states that persons differ from each other in their construction of events. These differences may occur

due to differences in the events experienced but may also occur due to differences in how people construe the same event. This position does not preclude a sharing of experience, as people can construe the events of others as well as their own and find common ground. Yet this common ground may not be found for cultural reasons, or if people do not seek out the common ground they have with others. This corollary may account for differences within professions. If professions are construed as each having their own cultures, it may be possible to understand why common ground between them is not sought.

5.1.3 The Organisation Corollary

The Organisation Corollary has also been touched on previously. Specifically it states that each person characteristically evolves, for their convenience in anticipating events, a construction system embracing ordinal relationships between constructs. This organisation of events can accommodate constructions of events that would normally be contradictory. That is, people can develop ways of anticipating events that go beyond these contradictions and keep anxiety at bay.

Kelly postulated that not only do people look for replication of events but they also seek to anticipate even the most unusual of events. To do this it is necessary to develop a construct system that will enable events, whatever they may be, to be anticipated in terms of familiar past events. The integrity and internal consistency of this system is important, and people attempt to maintain the system even when parts of it appear faulty, that is, when they do not predict events. This is the phenomenon usually labelled resistance in psychotherapy. The professional needs to

help the individual to find alternate constructions that will make this transition period less traumatic. If we think of mental health professionals working in the context of current mental health service provision models, these concepts become very useful in understanding some of the observations of Chapters Two, Three and Four. For example, some professionals who have difficulty incorporating the newer models of community treatment into their professional construct system, may be resistant to these newer approaches. Service administrators then, need to be aware of such situations and take these into account when developing new services to make the transition less traumatic and less likely to be blocked.

5.1.4 The Dichotomy Corollary

The Dichotomy Corollary states that people's construct systems are composed of a finite number of dichotomous constructs. The importance of this corollary is that it forms the basis on which much of the methodology of personal construct psychology is built. In its simplest form it means that professionals are able to construe similarities and differences between clients by contrasting them with one another.

5.1.5 The Choice Corollary

The Choice Corollary claims that: people choose for themselves that alternative in a dichotomised construct through which they anticipate the greater possibility for extension and definition of their construct system. Given that the notion of similarity and contrast in the construing process is accepted, then it is reasonable to propose that people will choose that pole of the construct (the

similarity or contrast) which provides the best anticipation of future events for them. This provides insight into why a person may still act in a manner that others consider to be “wrong”. Even given understanding by mental health administrators what the “right” action might be, to act in this way would still not elaborate or provide for the greater anticipation of future events for some mental health professionals.

5.1.6 The Range Corollary

The Range Corollary states that a construct is convenient for the anticipation of a finite range of events only. Just as there is a finite number of constructs that a person may use, there is a limited focus for each of these constructs. A construct is not relevant to everything, and its range of convenience can be narrow or broad. In order to understand mental health professionals we need to know not only the content of the constructs they use, but also the limits to which they apply them. It is only by doing so that we begin to gain some insight into their psychological processes.

5.1.7 The Experience Corollary

The Experience Corollary states that people’s construction systems vary as each person successively construes the replications of events. Through their experience they continually come into contact with unexpected events. In order to make sense of them they construe these events with their experiences providing validation, or invalidation as the case may be, for these constructions. These new constructions are actually the “hypotheses of the scientist” that are revised as the need arises from our experience. The essential nature of people’s experience,

within this theory, is that this successive construing of events, with their organisation of their experience, provides a certain orderliness to events. For Kelly these replications of events provide the “natural law” of the universe, accounting for its organisation. Within the context of the experience corollary the process of learning has been assumed and “it is not something that happens to a person on occasion; it is what makes him a person in the first place” (1955, p. 75).

How does the training of health professionals influence people’s constructs? Core constructs appear to be involved yet Bannister & Mair (1968) claim that Kelly suggested training deals with peripheral constructs. I believe that Kelly would differentiate between learning, a process that people are continually engaged in from birth, and training, a process that provides people with a much smaller subsection of experience to be construed within a subsection of their much larger construct system. I believe professionals take from their training those assumptions that can be accommodated in their present construct systems. Professionals seek validation for their models and if their experimentations using these models are not validated then they seek alternate models. This is the process by which professionals arrive at an eclectic stance in their work. It could also explain the observations made by Fransella (1983) that when these models are challenged they are defended so fiercely because they may tap into the professional’s more central constructs.

Further, these new constructions that professionals are presented with in training, may be more easily validated in some settings than in others. If the setting does not confront the professional with too

many problems, then they may be able to more easily accommodate their experiences. In the mental health setting, I believe that the problems that confront professionals are many, more complex and not so easily taken into account. Such a situation can lead to the view that mental health professionals are not effective and cannot understand their clients. It may also lead to disillusionment amongst professionals about their training.

5.1.8 The Modulation Corollary

The Modulation Corollary states that the variation in people's construct systems is limited by the permeability of the constructs within whose range of convenience the variants lie. Permeability refers to the degree to which a construct within a person's construct system is free to change without causing disruption in the person's life. This corollary, then, refers to the degree of change that can occur within peoples' construct systems and how this is so.

I have already referred to the subordinate construct system, the system in which constructs are most likely to change as a result of experience. The modulation corollary is referring to the degree to which a person's constructions of events are free to change within their construct systems. So although constructions of events can change from experience, this can only be so if they can be accommodated within the person's more central construct system. That is, professionals in training do not learn because of the nature of the events they experience, but because of the framework that they have designed to allow them to make sense of these events.

This is an important issue because if training only changes the professional's more peripheral constructions of events, or of their clients, then these constructions are those that are most easily modified. In this case it would be reasonable to assume that it would be likely to find less similarity within each professional group. Yet the research literature does not support such a position. On the other hand, if training changes more central constructs, then this must take place within the context of the values/beliefs that the professional brought to their training in the first place. This position suggests that only those theoretical constructions of clients/events that are most compatible with the professionals' original values/beliefs will be accommodated within their construct systems. Therefore certain types of professional training would attract certain types of people: a position supported by the research literature. In this case it would be reasonable to assume that similar client constructions could be identified for each profession.

5.1.9 The Fragmentation Corollary

The Fragmentation Corollary states that people may successively employ a variety of construct subsystems which are inferentially incompatible with each other. Within the context of the Modulation Corollary this is explained as follows. Some inconsistencies can be accommodated within subordinate construct systems, but generally it is expected that within the larger system of constructs the anticipation of events based on these inconsistencies will generally be effective. There is to some degree a thread of consistency to a person's behaviour due to the permeability of their construct systems. If however the constructs

of professionals are too permeable or do not function well together, they may frantically search for new concepts to make sense out of their work. This can result in weird behaviour and bizarre ways of anticipating reality. Such fragmentation occurs when the permeability of a person's superordinate construct system does not provide consistency for the person.

5.1.10 The Commonality Corollary

So far the corollaries have dealt mainly with the constructions of individuals. However the last two of Kelly's corollaries, the Commonality and Sociality Corollaries, deal mainly with people's shared constructions and their relationship to those of others. These have important implications for my research. The Commonality Corollary claims that to the extent that one person employs a construction of experience which is similar to that employed by another, the psychological processes of that person are similar to those of the other person. I have already briefly touched on this corollary. It means that if professionals construe clients differently, then they will anticipate them differently, and that if they construe clients in a similar way then they are likely to anticipate them similarly. This does not mean that the clients have to be similar or dissimilar, only their construction of them. This corollary also implies that if two people behave similarly then they may have similar constructions, and to this extent they are psychologically similar (Duck, 1982). Kelly makes a very interesting point in relation to the understanding of culture provided by this corollary. This corollary has extremely important implications for our understanding of the behaviour of groups. Kelly states that "people belong to the same cultural group, not

merely because they behave alike, nor because they expect the same things of others, but especially because they construe their experience in the same way” (1955, p. 94). I believe that this is an important corollary in understanding the “culture” to which the training experiences of professionals introduce them.

5.1.11 The Sociality Corollary

The last corollary, the Sociality Corollary, states that to the extent that one person construes the construction processes of another, he or she may play a role in a social process involving the other person. This corollary extends the Commonality Corollary in the sense that, not only must the members of a mental health profession have some degree of commonality with other members, but in order to effectively interact with them it is important for them to be able to construe from the other members’ outlook. This corollary allows for mutual understanding and interaction with others; but it does not imply that there is understanding of this kind between all interacting people. One may be better able to understand than to be understood. I believe that the process of professionalisation allows for those professions that are more advanced to be more understood by others, yet probably prevents its members from understanding members of other professions.

5.1.12 The Concept of Role

The concept of role describes the process by which the person construes the constructions of those with whom they are going to engage with socially. This emerges in people from their construing of the situation and can only be enacted according to the level of understanding they have of what constitutes the role. It is also

dependent upon developments within the social group and whether people are in agreement with their fellow members. Further, a person's perception of their role within the group need not be the same as that understood by other members of the group. It also does not imply commonality in the construct systems of those involved in the social process but rather an understanding of the other. Mental health professionals may have commonality of construction with other professionals; but, unless they make an attempt to engage socially with them, they will be unable to subsume their mental processes. This account is useful for understanding the complex interactions between professionals working in multidisciplinary teams.

5.2 COMMONALITY AND SOCIALITY: ADDITIONAL IMPLICATIONS FOR THE CONSTRUCTIONS OF MENTAL HEALTH PROFESSIONALS

Jahoda (1988) argues that personal construct theory is a theory of individuals and that the range of convenience of the theory does not enable it to include social psychology. However, although social relationships have been relatively ignored by workers who adopt a personal construct theory approach (Duck, 1979) there is little doubt that Kelly, in his very early work "Social Inheritance" (1930), maintained that our construing as individuals is influenced by those with whom we live. Bannister & Fransella (1986) note that Kelly set out a basis for social psychology in the sociality and commonality corollaries, with commonality relating to cultural and societal issues and sociality to relationships between individuals. In our society individuals are faced with many roles to choose from and these need to be appropriate for successful social interaction (Duck, 1979). Duck (1979) also argues that Kelly would have

answered the question of how people come together in the first place, by joining the commonality and sociality corollaries. That is, the similarity of constructs makes mutual understanding easier.

Duck (1979) extends Kelly's work by stating that this similarity provides for the opportunity for a person's constructs to be validated, and that the deeper the relationship, the greater the vulnerability of the participants. Duck (1979) goes on to say that similarity of construction to another and knowledge of them are not the same. What is important is to see that this knowledge and similarity can occur at several levels, and this determines the type of interaction that can follow. Relationships collapse if the validation of the construct system of a participant is weak, and the relationship will grow if the construct system is validated (Duck & Alison, 1978). It is therefore anticipated that validation of each mental health professional's construct system by another would lead to the development of closer relationships with that other. This is more likely to occur within the person's own professional group both because of greater availability and the greater likelihood of construct validation.

Interpersonal relationships are understood in terms of the Individuality, Commonality and Sociality Corollaries (Adams-Webber, 1979). Duck (1977; 1982) argues that the Commonality Corollary can only be fully understood in the light of the Individuality and Sociality Corollaries. Psychological similarity is evidenced by similar structure and content of construct systems, and commonality can change with a change in contexts.

The Individuality Corollary, in the context of interpersonal relationships, primarily emphasizes the influence of individual

differences on the structure and content of personal construct systems, and how these affect peoples interpretation of the behaviour of others in social contexts (Adams-Webber, 1978; Bannister & Fransella, 1971; Bonarius, 1965). Sociality is also explored by investigating how individuals make inferences about the personal construct systems of others. Such an activity is necessary for, and forms the basis of, effective communication and understanding of others (Adams-Webber, 1969; Adams-Webber, Schewenker & Barbeau, 1972; Mair, 1970a & b; Smail, 1972). There is now considerable evidence that commonality of constructions between people facilitates the development of role relationships, hence contributing to sociality (Adams-Webber, 1979). People also organise their social judgements about others. The extent to which the behaviour of mental health professionals seems consistent with the expectations of other professionals is in part determined by personal experience and society's norms.

5.3 THE PERSONAL CONSTRUCT APPROACH TO CHANGES IN MENTAL HEALTH SERVICES

Much has been written about the implications of personal construct theory for the intervention with and understanding of clients. Indeed Kelly stated that this was his main focus. Yet I believe that it is also useful in understanding the way in which professionals make sense of their work with clients, as well as providing a framework for understanding what occurs in mental health service provision in its broader context.

In this chapter I have begun to show personal construct theory's usefulness for understanding some of the research findings in this

area. I have also stated that mental health services are in the process of change, so it is reasonable to assume that the professionals within these services are also changing. Kelly's work provides some understanding of the difficulties encountered in the establishment of new services with different therapeutic orientations. Such difficulties will no doubt invoke many different emotions in the professionals working in such services. In personal construct theory terms emotion provides evidence of impending change in one's construct system. Kelly (1955) has outlined the types of reactions that occur in transition, and I shall explore these here.

Threat is the awareness of imminent comprehensive change in one's central or core constructs. The change must be substantial to rally this degree of emotion in a person and threaten the core of what the person has come to know of themselves and their world. Threat is an important concept in understanding the problems in the transitions that have taken place in the mental health field. Not only are professionals challenged by government policy and calls for increased power of clients, they are also challenged about the way they structure their work and are increasingly called upon to be more collaborative. As Fransella (1983) observed, when psychologists were debating their models of people "it seemed that it was not only the model of the person that was being defended by its proponents, but the very self-identity of the individuals themselves" (p. 91). She further noted that the debates were most heated when the person in scientific inquiry and the nature of the inquiry itself were discussed, resulting in a retreat to entrenched positions. This highlights the personal involvement of professionals in scientific inquiry and there is no reason to doubt that such

threat exists in the similar constructions involved in their provision of services to clients. It also suggests that the construct system that hold these constructs are central to the person.

Fear is similar to threat in that it indicates that change is about to take place in how a person construes events, but that the change is not as central to the person. Fear, then may be experienced by professionals when they have taken on the tenets of some of the changes required of them in their work in modern mental health services.

I have already briefly discussed anxiety, which is the recognition that the events which confront people are outside the range of convenience of their construct system. People become anxious and they are unable to make sense of what is happening. Many of the therapies advocated for the more serious mental health problems such as family therapy, psychoeducation and the community care model, are outside the range of convenience of most mental health workers. This of course is as a result of the training and socialisation of these workers. It may also account for the anxiety experienced by professionals when they are forced to work in multidisciplinary teams.

The emotion of guilt is defined as the apparent dislodgement from a person's core role structure. It is important to note that a core role is not a superficial one, but a role that is acted out as if the person's life depended on it. In the earlier discussion of roles I noted that role was an action based on how the person interprets the thinking of others. It should not be surprising that professionals experience guilt given the major changes that are occurring in mental health services. No longer are the traditional

roles as they used to be, but in a state of flux. I cannot help but return to the importance of professional training of mental health workers and the impact such training will have on their ability to function effectively in our current health system. I would also question whether it is guilt that partly contributes to the need for professionals to show allegiance to their profession by advocating the greater importance of their profession in comparison to others.

Of course the positive side of the challenge to a person's construct system is that some professionals will approach change by trying to elaborate their constructions of events. This elaboration can take the form of questioning, constantly challenging and actively doing. To other people these actions may be viewed as aggressive, and it is certainly my experience that such active attempts to understand one's world are not usually greeted with enthusiasm in the mental health field.

The last emotion I wish to deal with is that of hostility, which is defined as the continued effort to extort validation evidence in favour of a type of social prediction which has already proved itself a failure. This can occur in mental health professionals when they are faced with evidence that their way of working is not now validated in their setting. For example, psychiatrists who have traditionally been the leaders in mental health settings, and believe their leadership to be valid, may become hostile when the evidence is continually there that other professionals can equally well play the leadership role. Button (1985) has observed that in managerial systems it is often the case that managers are concerned with their own aims and that workers often fail to understand the aims of

their bosses, resulting in conflict. This conflict is a result of each person trying to obtain validation for their position. Of course there are many examples that could come from the transition from the traditional model of care and the reorganisation of mental health services. I shall now go on to talk more specifically about personal construct studies of the training of mental health professionals.

5.4 PERSONAL CONSTRUCT STUDIES OF THE TRAINING OF PROFESSIONALS

Surprisingly few personal construct studies address the impact of training on mental health professionals and those that do exist were mainly conducted in the early to mid seventies. Ryle & Breen (1974) found with social workers that the role of the supervisors in the training course were powerful. They also found that those constructs relating to their role were more stable throughout training, with constructs relating to affect less so. These latter findings were not expected by these researchers, however I believe that they indicate the power of the perceptions of the professional role.

Professional training can be seen as fulfilling two related purposes of education and socialisation (Tully, 1976). Training not only develops competence through learning skills and understanding, but also the person's professional identity and professional values. The socialisation process has been critically reviewed by Menzies (1988), who noted the anxiety-provoking process of developing competence in student nurses. She found that training had important implications for what were considered to be professionally responsible behaviours. It would seem that the roles

advocated in training for nurses encouraged depersonalisation of the client, an active encouragement to repress feelings of attachment and the development of detachment. Other tactics in training included the ritualistic approach to decision making which in effect limits options for action. The responsible nurse was one who adhered to these rituals. This finding is in agreement with that of Ryle and Breen (1974) who noted the rather intransigent nature of professional roles.

Lifshitz (1974) found, in accordance with the Commonality Corollary, that professional social workers differed in their constructions of clients as a result of the amount of training they had undergone. Specifically there was a change in their values and approach to people as a result of training. Winter (1992a) points out that this could be due to the social workers being older than the trainees. However it is also likely that training has had the impact of imparting what is expected in the role of social worker.

Tully (1976) states that the development of extended construct systems that are capable of being elaborated further when necessary, is not a guaranteed outcome of professional training, nor is the development of a sensitive open way of construing clients. He reviewed studies on the differences that exist amongst professional social workers in their construal of clients and the relevance their training might have for this. He states that there are very few studies of this kind but cites the work of Philip & McCulloch (1968) who found two clusters of construing. One cluster was associated with what they called professional formulations of pathology and the other with the way the client affected them as people. Tully suggested that there may be a split

in conceptual systems that developed through training between professional and personal functions.

Bender (cited by Tully, 1976) found that the construing of clients involved significantly more psychiatric terminology and that these constructs had a limited range of convenience suggesting that some evidence does exist for “two languages”, a professional one and a personal one. Soldz (1989) also suggests that therapists have different construct systems for clients than for acquaintances. He is in agreement with those who advocate that psychiatric nosology results in stereotyping (Sarbin & Mancuso, 1980) and an automatic attribution of a wide range of characteristics. It is of interest to note that the age, gender, profession, years of experience and theoretical orientation made no significant difference to the outcome in this study.

In a similar vein, Agnew & Bannister (1973) agree that there is a subsystem of specialist language in psychiatry, but that it is too poorly structured to be looked on as a specialist language. The problem for these authors is that the language used may have similar labels but not similar meaning. Soldz (1989) advocates more research that clarifies the exact nature of the differences in construal of clients and the possible implications that these differences have both clinically and socially. Soldz further asks if the separate subsystems for clients and acquaintances is in fact a way of alleviating therapist anxiety. The training of therapists does need to take this into account. As in practice, the excessive demands placed on professionals, the ritualised roles and the sensory overload placed upon them may further mitigate against a sensitive way of construing clients once training has occurred

(Tully, 1976). Again the importance of training mental health professionals is raised.

The type of training chosen by professionals is also important. Stone, Stein & Green (1971) found that the orientation of psychiatrists at the time of entry to their training was strikingly similar to that of their chosen training centre. Therefore training per se is less likely to be the only variable influencing the treatment orientation of professionals. Pallis & Stoffelmayr (1973) have reported on the surprising lack of studies of psychiatrists' attitudes and values, given that their importance have been stressed. In their study they found significant relationships between social attitudes and treatment orientation, with high conservatism associated with a "physical" treatment approach. These results suggesting that although the effect of training should not be minimised, it is likely that the attitudes that the person holds prior to training are also important in selecting treatment. Indeed, because clients usually cannot choose the psychiatrist they see, these authors call for psychiatrists to acknowledge the association between their social attitudes and the treatment they recommend.

Another interesting study is that by Green & Kirby-Turner (1990) who researched the change that took place amongst multidisciplinary professionals undertaking family therapy training. They found that there were no significant differences between themselves as they progressed through the group, even though it was quite obvious to their supervisors that such differences did exist, and were in fact easily identifiable. According to these authors the most likely reason for this is that the

participants played the game of “lets pretend we’re all the same” in order to try and establish a safe forum for risk-taking and experimentation. They called this a “pseudo-mutuality”. These findings are significant for they highlight the limitations that our research methods hold for the analysis of similarity and differences amongst mental health professionals. Again this is consistent with my argument already presented.

It might be timely then to address how we learn and accumulate facts. Thomas & Harri-Augstein (1977) argued “the source of a person’s attitudes is their personal knowledge and past experience evaluated within a personal system of beliefs and values” (p. 85). So people do not necessarily learn from experience, only from reviewing the meaning they attribute to it. In this context the authors define learning as “the construction and exchange of personally relevant and viable meanings” (p. 86).

Kelly’s concepts about learning are gaining increasing recognition amongst educators (Pope & Gilbert, 1985). Bannister (1979) proposed that the most important aspect of Kelly’s essay on social inheritance was that education should be about the personal meanings people give to their education. In science education the role of personal experience in the construction of knowledge is neglected (Pope & Gilbert, 1983). At present the role of the learner is that of “impotent reactor”; but, if we take the view that professionals construct their own world view, then it may be more comfortable for many educators to prefer to believe that professionals views are imposed on them by “the way things really are” (Pope & Gilbert, 1985).

Kelly (1970) argued that we spend a long time hoarding facts and would not be happy at the prospect of them being converted to rubbish by this process. We would more likely want to see them preserved as truths. This “clinging to truths” alleviates the professional of any responsibility for the conclusions that they may draw. Indeed it can be said Kelly was cynical of formal education, as he saw it as limiting the process of inquiry (Button, 1985). Kelly goes on to state that the expression of new ideas can be both distressing to ourselves and disturbing to others, leading to new ideas being kept to ourselves. The resulting emotions that could occur have already been discussed. Ideas are therefore not likely to be shared and become part of a culture. Indeed if the person has the view that authority is important, then they are likely to respect the knowledge of teachers as right, our theorising is also likely to be limited and the development of new knowledge stunted (Pope & Gilbert, 1985). This is a very important point, as people such as Grinder (1989) are just beginning to challenge our educational systems. Grinder points out that it is only those children who learn in a certain set way that proceed successfully through the system, others are abandoned by the system and/or forced out. This does not mean that the abandoned children were any less able.

Often in order to survive in learning situations people ignore that which they cannot bear, yet academics assume that people want to know more, and not wanting to know is often viewed as laziness, stupidity or lack of motivation (Mair, 1979). Mair goes on to state that most people do not want to know more than what they need to be able to cope, as it is both irrelevant and can be quite disturbing. He suggests that the pursuit of genuine questions at universities reflects a more dutiful practice of showing that you

have come to know what to ignore, and learnt to pose questions that lead to appropriate ignorance. This leads to knowledge that is not troublesome and presently acceptable.

Applegate (1990) states that in the interpersonal domain, inferences and behaviour are aimed less at predicting or understanding ourselves or others and more at accomplishing goals that are relevant for the situation. According to Applegate, people respond to others because they want to understand the immediate implications their behaviour has for their own goals rather than understanding why others behave as they do. To support this Applegate cites two studies that indicate that communication by health care professionals is tied to important health care outcome variables, including client compliance. Of course another argument is that professionals report on outcome variables as they are important to their role.

5.5 THE IMPLICATIONS OF THESE STUDIES FOR MENTAL HEALTH SERVICE PROVISION

I have already spoken of the usefulness of personal construct theory for understanding the changes that have taken place in mental health services. I shall now present other aspects of mental health services for which the theory is useful here. These include the professionals' working environment, related social environment and the cultural context within which they work.

Walton (1985) notes that job characteristics and work attitudes are not predefined or given, but construed from the information available from the person's social environment, their job and from past behaviours. The person will behave according to these

constructions. Individuals in the organisation will differ in their construction of events but will be able to interact to the extent that they can construe the other person's processes (sociality). This process does not rely on the similarity of beliefs about events but understanding of the point of view of the other. For Walton, in order to understand the organisation, the collective thoughts of those who make up the culture in the organisation must be understood.

In a similar vein Harri-Augstein & Thomas (1979) observe that professionals construct their social reality with other members of isolated close-knit communities, in which the construction of individual meaning poses little difficulty. Events are shared, and so are their constructions of experience which are mutually cross validated. The result is that their constructions go unquestioned. For the "society of mental health services" this can have disastrous effects. As Button (1985) says, "in the language of Kelly's choice corollary, a society preoccupied with definition at the expense of extension may lead to a neat order and security in the short-term but poses severe restriction on societal members and will be ill-prepared for eventual inevitable and possibly catastrophic change in the longer term" (p. 353). Mental health professions may be viewed as different societies with different cultures all functioning in mental health services. Each professional group looks to define their role or view of mental health or ill-health without extending to meet the needs of its client population.

Button (1985) adds a further dimension to this troubling description: "Behaviour and experience which may be labelled disordered, emerges within, gets "treated" within and may even

change within a social context. Patients, their families and their helpers all live in a shared world within which there are problems, possibilities, hopes and expectations" (p. 351). The question posed in this thesis then becomes: given their own attitudes or world view, that of their profession, that of their mental health service and their larger societal systems, how do therapists make sense of their relationship with clients?

5.6 SIGNIFICANT CONTRIBUTIONS TO UNDERSTANDING MENTAL HEALTH SERVICE PROVISION

Winter has been one of the foremost writers on the usefulness of personal construct theory for understanding mental health service provision. He sees it as providing a framework broad and subtle enough to accommodate the variety of available data (Winter, 1985c). Winter has also suggested that personal construct theory has implications for the organisation of therapeutic services. So far I have revealed research that needs to be integrated by a theoretical framework. This chapter has been devoted to providing the underpinnings of a theory that I believe, with Winter, provides this framework.

Winter (1982; 1985a; 1985b; 1985c; et al., 1987; 1988; 1990; 1992) has been concerned with: the views of clients; the matching of client to therapist; the outcome of therapy for clients as measured by grids and questionnaires; the reconstruction of clinical disorders; therapeutic alternatives for clinical disorders; the different treatment options adopted by professionals as a function of their more fundamental world view and "personal style"; the transition of staff through the changes brought about by the advent of community care; and the organisation of services so

that different theoretical orientations can be accommodated. My interests lie more in using personal construct theory to understand the similarities and differences within and between the various professions, and how training has influenced these. My aim is to provide a better understanding of the difficulties observed in the functioning of multidisciplinary teams, identify their implications for service delivery and for the training of professionals.

The most relevant of Winter's work for me then is his research on the "personal styles" of therapists and the usefulness of personal construct theory in understanding the provision of a therapeutic service. The basic philosophical assumption underlying personal construct theory, constructive alternativism, also provides a useful framework for understanding the way in which the members of different mental health professions make sense of their work with clients. Constructive alternativism asserts that there are many ways of construing situations depending on the meaning attributed by the construer. Winter (1985c) has pointed out that this assumption can accommodate the many psychological theories and be "technically eclectic while remaining rationally integrated" (p. 133). He acknowledges that not every professional will feel comfortable with all the available techniques. The extent to which a professional can accommodate in their construct systems the underlying assumptions of a certain approach, will determine whether the person will experience guilt or anxiety.

A personal construct psychotherapist does not have to be a Jack of all therapeutic trades. As an alternative, it may be that, just as personal construct psychotherapy can borrow techniques with diverse theoretical roots, a

service organized with an underlying philosophy of constructive alternativism can borrow therapists of different theoretical persuasions and yet maintain a consistent, rational framework (Winter, 1985c, p. 134).

Winter's work on personal styles began in collaboration with Caine and his colleagues' exploration of why therapeutic communities were less than successfully implemented. They demonstrated that the attitudes held by professionals to treatment, reflected their more general attitudes to life (Caine et al., 1981). These authors called this "the therapists' personal style", and they developed a battery of questionnaires that could be used to assess this style. These questionnaires will be more fully described in Chapter Eight of this thesis. Data from these questionnaires have consistently indicated that those individuals favouring a more medical approach to treatment hold more conservative outer-direction of interest, while those whose preference is for a more psychological approach to treatment are less conservative and have a more inner direction of interest (Caine et al., 1981; Winter et al., 1987).

These authors then extended their research to test whether these differences in attitudes were related to the difficulties in the establishment of new services. This research found similar findings to the research with therapeutic communities, suggesting that professionals in different treatment settings could be identified by their personal style. Caine et al. (1981) report numerous studies that also demonstrate that within the various professions it is possible to determine these different personal styles and orientation to treatment. It is also possible to demonstrate where these professions lie on a continuum of inner-directed to outer

directed. For example Winter et al. (1987) indicated that a significant difference existed between social workers, psychiatrists, occupational therapists, general practitioners and nurses. The social workers proved the most radical and inner-directed, and favoured a psychological approach to treatment, with nurses being at the other extreme of this continuum. Winter et al. (1987) concluded that there were differences between crisis team and non-crisis professionals in their personal style, although this was largely due to the different composition of the teams in terms of professional group and that "group differences of this order would suggest that interdisciplinary conflicts, ostensibly focusing on clinical issues, may in fact reflect divergences in the more basic assumptions, values, and social and political attitudes" (p. 237).

Emotions have also been shown to be aroused by the introduction of new services (Winter, 1985c). There were those professionals who invited change and those that were opposed; and, as Kelly (1955) noted, these emotions were evoked because people were aware of their transitions in construing. Professionals whose world view was very much reflected in their treatment preferences, were aware of the imminent threat to their core constructs (Winter, 1990). Winter (1990) observed that anxiety was also experienced as a result of the transitions in mental health services, with some professionals being faced with ways of working largely beyond their range of convenience. Guilt may also result from the awareness of the dislodgement from their core role structure.

Although the work of Winter provides information useful for understanding some aspects of how professionals make sense of their work with clients, it has relied, in this area at least, on the use

of questionnaire data. Questionnaires are limited in their usefulness because of their predetermined specificity (Viney, 1983a), and openness to socially acceptable responses (Viney, 1987). Widespread reliance on questionnaires has blunted our appreciation of the nature of human functioning, as there are usually firm limits placed on the kinds of answers that are allowed (Mair, 1977). Questionnaires cannot tell the meaning or sense that is attributed by the respondents, nor the extent to which professionals can understand the construing of others. Even though they may be using similar constructs, they may not be using them in similar ways. They would not then be able to understand the world of the other. The structure of a person's construct system as well as its content is important.

Other problems I believe arise from the use of questionnaires centre on the question: exactly what are they assessing in terms of the person's construct system? Do they measure core constructs, or certain subsystems of the person's construct system? Questionnaires may provide some information on the differences that exists between respondents, but they are unable to inform about the quality of the similarity that exists when group comparisons prove not to be significant. More recent studies (Gournay, 1986; Tooth & Stanton, submitted for publication) using two of the questionnaires developed by Caine et al. (1982), also appear to be indicating some different results to those originally obtained.

Specifically, Gournay (1986) found that following a training program, respondents' scores on the Attitude to Treatment Questionnaire (ATQ) were the only scores to differ from the

pretraining situation. The Direction of Interest Questionnaire (DIQ) scores were similar pre and post training. He found some evidence to suggest that respondents were giving responses that they thought to be socially acceptable. In a similar vein, Tooth & Stanton (in press) found that with 102 nurses working in three different mental health treatment settings, the DIQ did not discriminate significantly between these three groups, but that the ATQ did for at least two of the groups. These authors have concluded that the ATQ could be measuring socially acceptable responses. I believe it is reasonable to argue that the ATQ is prone to such bias. It has been made very clear world-wide, through the implementation of new policies, that mental health services are to be community-based and person-centred. I doubt that many mental health professionals today do not know what the most appropriate responses are, and this is in part being reflected in their responses on this scale. The time has come to add more constructivist research methods to our inquiries.

5.7 SUMMARY

In this chapter I have presented an account of personal construct theory and showed how it may be useful in providing an integrating conceptual framework for the research presented in Chapters 2, 3 & 4. I have presented an outline of Winter's model that shows the usefulness of constructive alternativism for understanding mental health service provision and how the problems in this transition period can be understood within this theoretical framework. I have also provided additional examples of the theories useful for this purpose. I have also argued that personal construct theory is useful

for understanding the similarities and differences that might exist within and between the mental health professions.

Evidence exists for a well organised construct system for professionals to understand their clients and make fine distinctions about them. However, Agnew & Bannister (1973), while agreeing with the existence of such a construct system, argue that it is poorly structured. I have also shown that professional training is not the only variable that influences professionals' work with their clients, and that their personal experiences, beliefs and values prior to training are important. I have argued that professionals are more likely to take from their training those aspects that can be accommodated in their existing world view. I have also suggested that each of the professions may be viewed as having their own culture and that training is the socialisation of professionals into that culture. I would also argue that one of the most powerful aspects in this culture is the introduction of what is expected of the professional in their role.

I have also argued that George Kelly probably had a different meaning for learning and for education: learning being a process of reconstructing continually from birth with the full construct system, and education being the imparting of facts to be accommodated in a smaller subsystem of constructs. I have suggested that if the professional is not presented with too many problems by their clients, then they may well be able to practice without too many challenges to this construct system. Yet if, as is the case in many mental health services, the professional is confronted with clients who have multiple mental health problems

and with a way of working for which they were not trained, then difficulties in service provision are bound to arise.

The above assumptions are based on the evidence that suggests that members of each of the mental health professions are similar to one another but different from members of other professions. Training would be expected to have influenced these patterns, but the values each professional brought to training have also been shown to be important. The time has come to apply these assumptions. In the next chapter I shall describe the constructivist method I chose to use in this research.

CHAPTER SIX

ASSESSMENT OF MENTAL HEALTH PROFESSIONALS' CONSTRUCTIONS OF THEIR CLIENTS

In the previous chapter I presented a summary of personal construct theory, some relevant work of researchers who adhere to this approach and showed the usefulness of personal construct theory in understanding a range of aspects of mental health services. I concluded by pointing out the need to expand our methods of inquiry, if we are to gain greater understanding of how mental health professionals make sense of their work with clients. This chapter is devoted to the use of methodology consistent with personal construct theory and addresses the issues raised by doing so. At the end of this chapter I shall also present information about the questionnaires that were used for comparative purposes in this study.

Bannister (1981) has observed that most psychological theorising has little to say about research method and that much of the research design is not derived from the theory. Personal construct theory he saw as having had research design incorporated into it from the beginning. Its model of person-as-scientist and its reflexivity make this so. For constructivist researchers, then, research is a formalised version of the informal inquiries of everyday life. Bannister (1981) likens this to the Circumspection, Pre-emptive and Control (CPC) cycle that occurs in normal inquiry. In the first stage of the cycle, circumspection, many questions are pondered on and arrived at from many different sources. From this stage emerges the general issues to be taken into account. In the second stage, the pre-emptive phase, we begin to see the kinds of questions that we wish to ask. In the final stage, the control phase, the questions are asked in operational terms, so that specific answers can be achieved. The questions in this phase can be open-

ended, with the important point to be made that this form of inquiry is in fact a cycle. For Bannister staying with one method of psychological inquiry is analogous to being stuck at one stage of the CPC cycle.

The most popular method of inquiry in constructivist research has been the Repertory Grid. The most important aspect of this methodology is that it provides measurement of construing while at the same time preserving the meaning that people attribute to events. The almost exclusive use of grid methodology has been questioned (Neimeyer, 1985) and the use of other forms of methodology advocated (Bannister, 1981). The underlying assumption of personal construct theory, constructive alternativism, provides the researcher with a theoretically sound base from which to devise other forms of methodology. Further, the reflexivity or the application of the theory to the users of the theory, enables the researcher to choose personally relevant issues to research and to draw on personal experience to do so.

6.1 THE ASSESSMENT OF CONSTRUCTIONS

Much of the research I have reviewed so far has involved the measurement of attitudes. In constructivist theory, attitudes refer to people's general evaluation of certain objects (O'Keefe, 1980). O'Keefe notes that findings suggest that attitudes are typically not well correlated with behaviour, therefore we need to know what is meant by "attitudes" and "behaviours". Constructivism denies that attitudes are important direct determinants of behaviour, but sees them rather as context relevant beliefs. Indeed constructivism has little use for a concept of general evaluation of an object. The importance of attitudes, then, lies in their role in the organisation

of the person's belief system. Generalised evaluations of objects can serve, then, as organising principles of a person's construct system.

In this research, then, I am not concerned with measuring attitudes but with measuring how people construe events and how they organise the constructs they use in their construct systems. The way we look at things determines what we do about measuring them (Bannister & Fransella, 1971). In personal construct studies the main way of measuring constructs and their structure has been through the use of Repertory Grids. When Kelly (1955) devised the Repertory Grid as a method of determining the mathematical relationships between constructs, "he provides the future user of the technique with their own method of non-parametric factor analysis" (Bannister & Fransella, 1971, p. 48). However, as Neimeyer, Baker & Neimeyer (1990) note, the once predominant use of Repertory Grids within the empirical literature is gradually being eroded. In the next section I shall present information on both Repertory Grid and interview methodologies that are relevant to my research

6.1.1 Repertory Grid Methodology

Just as the measurement of attitudes poses many questions, so does the use of Repertory Grid methodology. This method has been frequently used without reference to the theory and viewed as some sort of measure of attitudes, personality or concepts (Fransella & Bannister, 1977). It is therefore important to understand its derivation from the theory and the assumptions implicit in its use. Kelly viewed people as "scientists", constructing their hypotheses that are based on their personal experiences, then

testing them. As a result of their experimentation they can then modify their theories if the need arises. This process occurs as a continuous cycle. The Role Repertory Test was originally devised by Kelly (1955) to tap into this cycle, and consisted of 24 significant roles for the person who was then to elicit constructs based on these elements. The Repertory Grid is an extension of the Role Repertory Test and was also devised as a method of exploring relationships within our personal construct systems. There are different types of grids. These include the Standard Grid, Dyad Grids, Dependency Grids, Implication Grids and Resistance-to-Change Grids (Button, 1985). The Standard Grid was selected for this research.

Repertory Grids can also be seen as an attempt to understand how other people use constructs to see the world (Fransella & Bannister, 1977). Kelly's (1955) definition of constructs implies that they are bipolar. People know things are similar when they see them both as different from something else. It is this bipolarity that allows for the design of grids (Fransella & Bannister, 1977). In a grid the things that are construed are called elements. It is, then, possible to rate by various methods how each of the constructs relate to the elements. This capacity to look at this relationship between the elements and constructs gives us much more information about how each person makes sense of their world and organises the constructs they use to do so. Understanding the constructs that other people use and how they organise them makes it more likely that we will be able to effectively communicate with them.

Four corollaries of personal construct theory (Kelly, 1955) are important to the use of Grids. The first one, the Range Corollary, requires that the things that people construe, the elements in the case of the Repertory Grid, must be within the range of convenience of the respondents. If this is not so, then those respondents will not be able to make any sense out of the task at hand. The Individuality Corollary indicates that each person will have their unique way of perceiving events, and the Repertory Grid has been designed to provide a means to explore such individual meanings. At the same time grids may also provide information on the commonality in the construction of events. The Commonality Corollary states that people are able to understand another person if their construction of experience is similar to theirs. Repertory Grids can also provide information on the organisation or structure of peoples' construct systems, eliciting ordinal relationships between constructs.

Two other important issues in the use of Repertory Grids are the choice of elements and the derivation of constructs. While the elements must be chosen so that they are within the person's range of convenience, they are also chosen so that they represent the area to be studied. In some cases, to ensure that the elements are within the person's range of convenience, they are elicited from that person himself or herself. In other circumstances they may be supplied by the researcher, but they must be representative of the pool from which they are drawn (Fransella & Bannister, 1977). The definition of that pool depends on the needs of each individual study.

There are also a number of issues involved in the elicitation of constructs. As with the elements, constructs can be either supplied or elicited. The essential task in supplying constructs is to ensure that they have meaning for those who will use them; and, as Fransella & Bannister (1977) have pointed out, the decision to supply or elicit constructs depends on the purpose of the Repertory Grid. Lemon & Warren (1974) have found that more extreme ratings are made with elicited as opposed to supplied constructs, suggesting that elicited constructs have more meaning for those using them. Extremity of ratings have also indicated more meaningfulness for elicited constructs in studies conducted by Landfield (1971) and Bonarius (cited by Landfield, 1971).

There are a number of ways in which a Repertory Grid can be scored. These consist of dichotomous scoring, ranking and rating of constructs. The reader is referred to Button (1985) and Fransella & Bannister (1977) for a more detailed account of these alternatives. What is important here is to expand on the rating method used in this research. This is the commonest form of rating and the 1-7 scale being the most popular type (Button, 1985). It also gives people completing the Repertory Grid more flexibility in responses than other methods (Fransella & Bannister, 1977). Yorke (1983) does however raise questions about the actual meaning of the mid-point in such rating scales, as there may be more than one interpretation of their meaning. It is therefore advisable to make explicit the meaning of the mid-point in the use of the 7 point scale.

There are also many ways for eliciting constructs, with the triadic elicitation method being the most popular (Button, 1985). The

triadic method, the one chosen for this research, consists of selecting three elements from the total number of elements and asking how these are different from or similar to each other. There are a number of ways of choosing the triads and these may be from randomly selected sorts or on the basis of pre-determined sorts (Button, 1985). Bender (1974) suggests that the triads should be as varied as possible and that a large number of sorts should be present, in order to prevent the distortion that sequential ordering of the elements can produce.

The next point of discussion I shall turn to is that of the analysis of Grid data. Of course if the Grid is used in the clinical setting it is possible that no analysis will be carried out. Another method is that of eyeballing the grid, providing it is not too large (Button, 1985); however the more formal version of eyeballing involves the statistical analysis of the grids. There have been many programs designed for this purpose and they are concisely summarised by Sewell, Adams-Webber, Mitterer & Cromwell (1992). The reader is referred to these authors for a more detailed account of these programs. I shall concern myself here with the program most suited to this research, the Rep Grid program (Shaw, 1989) a more advanced version of the original Planet program (Shaw, 1982). The Rep Grid program also is not subject to the mathematical flaws identified by Mackay (1992) in other programs. Specifically it is the Socio Program of the Rep Grid that is of interest to this research, as it allows for the measurement of similarity and difference in groups of research participants, a major focus of this thesis.

The Socio Analysis, a component of the Rep Grid Program, was designed to compare different construct systems that have the same elements, constructs or both, and demonstrate the similarity and differences that exist within the group under study. The aim of the program is to allow groups of people to work together to understand differences that have the potential to lead to conflict and provide a framework for resolution, as well as enrich the group's appreciation of each other's similarities and differences. This is done by comparing the "structure" of their construct systems rather than by comparing content descriptive terminology. As Shaw & Woodward (1990) state: "people may use the same term for different constructs, use different terms for the same construct, use the same term for the same construct, or use different terms and have different constructs" (p. 1). Two people may use different terminology, but if the way in which they use this terminology is similar (that is the structure is similar), then an important basis exists for mutual understanding of differing terms. The Rep Grid program has two other forms of analysis. It can identify the "mode constructs" for the group and can provide "socionets".

The mode constructs are those constructs that reflect a consensus within the group. This is done by extracting those constructs that are highly matched across the majority of the group. The PAIRS algorithm provides a list of the constructs most often used by all members of the group in descending order of average match values. To find these values each construct is compared with every other construct in all the Repertory Grids. The individual constructs are not altered in any way. A cut off point can be taken at any point and is dependent on the needs of the project.

The socionets, or construct links as they are also called, show the degree to which each person is able to make the same distinctions as another person even if they use different terminology. This analysis provides information on those members of the group who have the greatest degree of commonality in rank order down to those that have the least. The validation Shaw & Woodwood (1990) suggest for this procedure is to compare the obtained information with the known relations between the group.

In this research only the elements were common to all grids and the constructs were elicited from each participant. Within the framework of the Rep Grid program, this allowed for the demonstration of the “correspondence” and “contrast” that exists within and between the groups. Correspondence is the degree to which members of the group are likely to understand what the other is saying without necessarily using the same constructs. By comparison, contrast is the degree to which members of the group are not likely to understand other members’ construing. The theory underlying these concepts is Kelly’s theory of the structure of an individual’s construct system and draws heavily on the Individuality, Commonality and Sociality Corollaries. Unfortunately the program is limited in that it can provide analysis of up to 20 grids only at any one time.

6.1.2 The Reliability and Validity of Grid Measures

The terms reliability and validity need careful consideration in relation to personal construct methodology. Reliability traditionally means the ability of a tool to measure something consistently over time. This is problematic for us constructivists, as our theory is about change, not stasis. Therefore it is

reasonable, if we see people in action and hence constantly changing, that we would expect that some change is to be anticipated, but also that there should be some stability in the construal of events. Validity traditionally means the ability of a tool to measure what it purports to measure. Yet if we respect that each person's interpretation of their experience is as valid as our own, validity takes on a different meaning. It is no longer about whether a tool measures what it purports to measure, but about the broader usefulness of it.

The reliability of Repertory Grids has been studied both empirically and theoretically, with the earlier studies trying to establish empirical reliability, while the later ones are more concerned with theoretical discussions of the reliability of Grids. The consistency of the pattern of construct relationships over time yield reliability coefficients within the range of 0.60-0.80 (Fransella & Bannister, 1977). As the constructs in this research were elicited from participants, it is necessary to report on the reliability of such constructs. Fjeld & Landfield (1961) found a correlation of 0.80 of elicited constructs from the same elements over a two week interval. The reliability of the elements has been variant and dependent upon the nature of the elements in the particular grids (Fransella & Bannister, 1977). In a later review, Fransella (1981) concluded that "average reliabilities tend to be quite high, but the range for individuals making up the sample is often very wide" (p. 173). More recent reviewers (Adams-Webber, 1987; Bell, 1988) similarly argue for the high reliability of Repertory Grid techniques. A recent empirical study (Feixas, Moliner, Montes, Mari & Neimeyer, 1992) reported a test-retest reliability of .85 for the structural measures over a one month period.

The validity of grid methodology from a constructivist perspective can be measured in terms of its usefulness, that is if it is useful for the person to communicate their experience in such a way that it can be communicated to others (Fransella & Bannister, 1977). The usefulness of grids in clinical practice and research is well documented by Landfield & Epting (1987) and Winter (1992). In his review of the validity of Repertory Grid measures, Winter (1992) concludes that there is “considerable evidence of the validity of repertory grid measures in relation to a wide range of characteristics and aspects of the behaviour of ‘normal’ subjects, as well as giving a picture of the process of construing of such individuals” (p. 65).

6.1.3 Interview Methodology

Most of the tools to explore personal construct theory have yet to be invented, and those that go beyond grid technology are still at a very early developmental stage (Thomas, 1979). Calls are now being made for a wider use of methods of data collection and for the analysis of the resulting data with the focus being on their meaning (Viney, 1988). Interviews can then also be used to focus on the meanings of the mental health professionals in my inquiry. Interviews are also consistent with Kelly’s (1955) philosophy that if you want to know something of someone, ask them and they may tell you. The use of such methods relies on the development of a good relationship with the research participants, and unfortunately this has often led to the abandonment of this form of inquiry (Leitner, 1985). Leitner argues that the relationship should be used to gain greater access to the other’s world. In his research he found that participants rated the constructs obtained from the

interview as more important to them than those obtained from grid methodology.

Interviews that focus on the meanings of the participants can supplement quantitative methods (Viney, 1992; Viney & Bousfield, 1992). Leitner (1985) has suggested that Repertory Grid methodology can add rigour to a more conversational methodology, as the research does not then solely rely on peoples' verbal descriptions of their constructions of their experience. This, together with the ability to analyse the themes obtained from interviews, which has been greatly enhanced by the use of computer programs (Richards & Richards, 1991), shows promise in the marriage of qualitative and quantitative methodology. In this research both methodologies will be used.

6.1.4 The Questionnaires

In his review of the literature relevant to this research, Winter (1990), describes the many studies that have used two questionnaires and they will therefore be included in this research. The Attitude to Treatment Questionnaire (ATQ) has been shown to successfully differentiate the two broad approaches to psychiatric treatment, namely the psychological and the organic. Component 1 of the ATQ gives the most consistent measures of psychological and organic approaches to treatment. Reliability coefficients of between 0.79 and 0.76 have been reported with nurse samples (Caine et al., 1981) over a period of three months. Component 1 only was therefore included in this research.

The Direction of Interest Questionnaire (DIQ) is a short 14 item questionnaire derived from the following personality inventories:

the Cattell 16 PF; the Myers-Brigg Indicator (S/N Scale); and the Kuder Personal Preference Record (C Scale). The scores on the questionnaire represent the “inner” direction of interest, defined as a concern with ideas, imagination, theory, philosophy et cetera, as opposed to outer direction of interest, concerned with facts, practical problems, science, action and common sense (Caine, Wijesinghe & Winter, 1981). These authors report a retest reliability coefficient of 0.84 for the DIQ over a period of three months, and acceptable validity because it is able to order professions in terms of their interest patterns.

The developers of the ATQ and the DIQ (Caine, Wijesinghe & Winter, 1981) report an acceptably high validity for both scales on the criterion measures for each. The ATQ and the DIQ have also been found to be inter correlated (Caine, Wijesinghe & Winter, 1981). To date these questionnaires have been the only tools used to assess professional attitudes to treatment in relation to personal preferences. For this reason they were also used in this study to see if these results could be replicated with Australian mental health professionals.

6.2 SUMMARY

In this chapter I have detailed two ways in which constructs may be measured within the framework of personal construct theory. I have also provided detailed information on the ATQ and the DIQ, the two questionnaires used in this research and described my reasons for choosing these methods. The Repertory Grid has been shown to be both a reliable and valid tool, while interviews have been shown to provide more information on the meanings that

professionals attribute to their work with clients. I have argued that qualitative and quantitative methods add rigour to research.

I have stated elsewhere that in the process of research it is important for the researcher to tell how they have arrived at the issues they think are important to study. In doing so it becomes clear to the reader not only why the questions have been asked, but also provides an understanding for the choice of methods to answer these questions. In the next chapter I shall present my experiences, and my questioning that took place as a result, and describe the aims of my research and the questions on which it is based.

CHAPTER SEVEN

THE HISTORY, AIMS AND RESEARCH QUESTIONS OF THIS RESEARCH

I have identified the need for research methods to be integral components of a good psychological theory and how personal construct theory provides such methods. Research is a formalised version of informal human inquiry. I have also shown that being explicit about the values and the process by which researchers arrive at their research questions is important if their understandings are to be shared. Personal construct theory allows for, and even encourages, such reflexivity. In this chapter I shall show how I arrived at this formalised inquiry. In so doing I shall be presenting the circumspection, preemption and control cycle of my research inquiry.

Because I am registered to practice as both a nurse and a psychologist in this Australian state, I have found myself in a unique position. I have felt that while working in either of these professions my colleagues somehow viewed me as different from them. I was not quite one of the flock. I began to observe these reactions more closely and take notice of, and talk to, other people who were in a similar position to mine. I found that people in a similar situation often had experienced similar reactions from colleagues, while others went to great lengths to denounce the less preferred profession of the two. I had no trouble combining my dual training, and I must say that I have never seen the need to identify myself as belonging to solely one profession. For me, my dual training has simply enabled me more varied experiences to those of most of my colleagues.

It was natural for me then to take up an appointment as a psychologist in a multidisciplinary mental health Crisis Team. This team was newly established in the Illawarra Area Health Service

and soon began to suffer the same fate as those new services I have described earlier. I considered that the service the team was providing was exciting and offered many new alternatives to clients and their families, that to date, they had been unable to receive. The clients and their families were very appreciative of the service, and we had success with many difficult clients. Yet our integration into the existing services was not smooth. Many other Crisis Teams in New South Wales proved to be experiencing similar difficulties.

I have reviewed here the available literature addressing these issues. The material I have presented in the preceding chapters represents the circumspection phase of the CPC cycle of my inquiries. Although I could see that there was use in what most of these authors had to say, I still judged there to be something missing. This was because I worked with nurses who I consider have a very organic approach to treatment, and, given my very psychological approach we still managed to work together quite well. However I still remember their saying to me: "You are not really a psychologist".

At this time there was a political push to determine who in fact could supervise/administer medication in these multidisciplinary teams. One argument raised was that only nurses could perform this task. As I was administering medication, and legally able to do so because I was still registered as a nurse, I sought clarification of my position from the Illawarra Area Health Service's Board of Directors. I was told that to continue the administration of medication would have legal implications for my future employment in the Service. This is all the more interesting because it occurred at the same time that multi-skilling was being

introduced to workplaces across Australia, multidisciplinary teams were being set up and generalist mental health workers were being sought through advertisement.

In the pre-emptive phase of my inquiry I became increasingly focused on the question of the uniqueness of each of the mental health professions. I have no doubt that each of the professions has something unique to offer to our common clients, and this seems appropriate given the specialist training each profession receives. Yet there is a degree of overlap between the professions, which to date no-one appears to be able to identify. Superimposed on this is my experience that we as professionals seem to believe that the members of other professions are different from us, and that those of us who belong to the same profession are the same. Of course I do also expect that training would be a significant influence on both how we work and how we make sense of how we work with clients.

In the control phase of my enquiry, then, I did not seek to find some predetermined factor, as measured by questionnaires, but returned to a position of ignorance. That is I wanted to understand how mental health professionals make sense of their work with clients, how their constructions are similar and yet different, and what role their values and training play. As I began the research I had no preconceived ideas of what the outcome would be. I wished only to engage in coming to understand these issues in collaboration with my research participants.

To do this I decided on the use of first qualitative and quantitative methodologies in the form of open-ended interviews and Repertory Grids, to add the rigour to my research, but also to allow me the

privilege of hearing what the other mental health professionals had to say. I hoped that the interview data would enable me to better understand how mental health professionals make sense of their work with clients, and what role their values and training played in this. The Repertory Grid was used to provide me with information both on the content of the professionals' constructs and also on their structure, in other words, the way in which they used these constructs.

I also decided to use two of the questionnaires devised by Caine et al. (1981) as these have been the main tools used to understand the conflict that exists in mental health services. The use of these tools will therefore enable some comparison between my sample and those reported in the many well replicated studies cited so far. I compared information from people from the professions of psychiatry, psychology and nursing. I shall now present the formalised research questions that have guided this research.

7.1 Research Questions

1. When mental health professionals describe their work with clients, will a pattern of construct content be identified for each of the professions?
2. If such patterns of construct content are identified for each of the professions, will there be differences in them between professions?
3. Will the members of each profession share the same construct usage?

4. Will there be differences between members of different professions in the way they use their constructs?
5. When mental health professionals describe factors relating their success or failure with clients, will a pattern of such factors be identified?
6. If such patterns of success and failure factors are identified for each of the professions, will there be differences in them between professions?
7. What role do personal values and professional training play in how these professionals construe their clients?
8. Will the group of psychiatrists have the most organic approach to treatment of the three groups? Will the psychology sample have the most psychological approach to treatment? Will the nursing sample have an organic approach to treatment but less so than the psychiatry sample?
9. Will the group of psychiatrists have the most outer direction of interest in relation to client problems of the three groups? Will the group of psychologists have the most inner direction of interest? Will the group of nurses have an outer direction of interest, but less so than the psychiatry sample?

In the next chapter I shall present the information necessary for the undertaking of this research.

CHAPTER EIGHT

RESEARCH PARTICIPANTS AND PROCEDURES

The participants in this research were mental health professionals in the Illawarra Area Health Region and a hospital unit in the adjacent Southern Metropolitan Area Health Region of Sydney, New South Wales. A mental health professional was defined as a person working in one of the mental health services, either in the community or hospital setting, and with at least one year's experience in such a service. I had been working as such a professional in the Illawarra Area Health Region for the past five years. Because of the intensive and resource-consuming nature of the data collection and analyses, only 20 participants from each of three professional groups could be sampled.

8.1 THE RESEARCHER

Since I was using Kelly's (1955) theory of research, I considered myself to be a co-researcher with the participating mental health professionals. As a person with substantial professional mental health experience, I felt I was able to be very open and honest with the other participants about the questions that had arisen for me while working with clients and to enlist their assistance in answering these questions. I conveyed to the participants my interest in understanding how we as therapists make sense of how we work with our clients, and to explore what commonality and differences existed between different mental health professionals. I also explained that these questions had arisen from my experience working as a registered nurse and as a registered psychologist in the mental health field. The sharing of my experiences with the participants appeared to enable them to be open and comfortable when talking with me subsequently.

8.2 THE PARTICIPANTS

The research was primarily conducted in the Illawarra Region of NSW, Australia. The region is an urban industrial microcosm of approximately 250,000 people; 30 kilometres from the southern outskirts of Sydney, a city of 5,000,000 people. The Chief Executive Officer and the Director of Psychiatric Services for the Health Care Service were contacted prior to the commencement of the study to obtain permission to conduct the research, and they agreed with enthusiasm. The mental health care facilities in the region include: two inpatient psychiatric units, one of which is gazetted under the Mental Health Act to take involuntary clients, with a total capacity of thirty five beds; a community service that has a Mobile Treatment Team whose function is to provide both crisis intervention as well as assertive follow-up of clients; a community nurse team that provides less acute and more long-term support for clients and their families; a day care centre and an extended hours team in the southern section of the region; a rehabilitation service consisting of three living skills centres, two vocational centres, and a variety of accommodation options ranging from fully supported living to independent group homes. The Southern Metropolitan hospital unit contains 25 beds and provides an outpatient service for clients.

The mental health professions chosen for the research were registered psychiatrists together with psychiatric registrars, registered psychologists and registered psychiatric nurses. Social workers and occupational therapists were not included because of the very poor representation of these professions in this state's

comprehensive mental health services. A summary of the demographic data of these samples appears in Table 1.

Table 1
Demographic Data for the Participants

Profession	Age Range	Mean Age	Women	Men	Years of Experience Range	Mean Years of Experience	Hospital	Community
Psychiatry	25-62	39	6	14	1-34	11.4	12	8
Psychology	25-45	36.3	9	11	1-22	9.25	1	19
Nursing	26-57	37.7	11	9	1.5-23	11.4	10	10

8.2.1 The Psychiatry Sample

The Illawarra Region has a total of 13 psychiatrists and five psychiatric registrars. This total group were asked to participate in the research and their response rate was 78%. To obtain twenty psychiatrists or psychiatric registrars for the research, these professionals at the Southern Metropolitan hospital were contacted by letter and asked to participate. The response rate was 100%, giving a total of 15 psychiatrists and 5 psychiatric registrars who participated in the research. The age range for this group was 25-62 years with a mean age of 39 years and there were 6 women and 14 men. The range of their years of experience in mental health was 1-34 years with a mean of 11.4 years. Fifteen of the psychiatrists were born in Australia, two in India, one in England, one in Canada and one in Croatia.

8.2.2 The Psychology Sample

There was a 100% response rate from the 13 psychologists employed by the Illawarra Area Health Service. To obtain 20 psychologists for the study, a standard letter was sent to all psychologists who had completed their practical placement for the Master of Arts (Clinical Psychology) or PhD (Clinical Psychology) in the Psychological Services Unit of the University of Wollongong, in that same Region. This ensured that all participants had experience working with clients in an Illawarra mental health setting for at least one year. The age range of the psychologists who participated was 25-45 years of age, with a mean age of 36.3 years, and there were 9 women and 11 men. The range of their years of experience in mental health was 1-22 years, with a mean of 9.25 years. Fifteen of the psychologists were born in Australia, four in England and one in Ireland.

8.2.3 The Psychiatric Nursing Sample

There are 74 registered psychiatric nurses working in the Region. Thirty-five of these worked in the in-patient units and the remaining thirty-nine work in the community. Of the 20 nurse participants, 10 were chosen from the units and 10 from the community by the means of a table of random numbers. The nurses were all contacted personally and informed of the research and asked to participate. The age range for this group was 26-57 years with a mean age of 37.7 years, and it contained 9 men and 11 women. The range of their years of experience varied from 1.5 to 23 years, the mean years of experience being 11.4 years. Thirteen of the nurse participants were born in Australia, five were born in England, one in South Africa and one other in West Germany. Only

one nurse who was asked to participate declined and was replaced by another nurse chosen through the random allocation method.

It is important to point out that for my sample, no significant differences were obtained between the three professional groups on age, gender, or years of experience; using the ANOVA program. This finding suggests that these groups were reasonably well matched.

8.2.4 The Representativeness of the Research Sample

It was difficult to determine the representativeness of my sampling of the mental health professionals of this state of New South Wales, because the relevant information about their parent populations is not held within a central body. I was only able to obtain the mean age for each population of professionals, but not the gender distribution. For the psychiatrists registered in this state, the mean age is 47 years. This includes those working in both the public and private sectors. The younger mean age of my sample of psychiatrists is most likely due to them being drawn predominantly from the public sector. For the psychologists the mean population age is 42 years. This information is for those in New South Wales who are members of the Australian Psychological Society. Again the overall mean age is for psychologists working in this state regardless of work setting and it is notable that my sample is somewhat younger. For the nurses, the mean population age is 37 years for those nurses registered in this state and whose predominant place of employment is mental health, and is comparable with the mean age of my nursing sample. However, even though I have not been able to fully establish the representativeness of my samples in demographic terms, I would

point out that to date the research literature has consistently reported age, gender and years of experience are not important variables in the responses given by research participants in this field of inquiry.

8.3 MATERIALS USED FOR DATA COLLECTION

8.3.1 The Working with Clients Grid

The Repertory Grid was used to elicit twelve bi-polar constructs from each participant. The elements in the Grid were chosen by the researcher. The procedure for doing this consisted of choosing the ten most common diagnostic categories from the DSM III-R. Then, to avoid the use of “labels” that may seem incongruent to some of the research participants, a more general descriptive phrase was used to represent these categories. For example, instead of using the term affective disorder, the phrase was “a person who has a great deal of problems with their moods”. To check the validity of this re-categorisation a clinical psychologist, who was not involved in the research, was given the list of DSM III-R categories and the phrases devised by the researcher and asked to match them. The reliability of matching achieved was 100%. Two additional categories were added to give a total of twelve elements. These were “clients with whom you feel comfortable” and “clients with whom you feel uncomfortable”. These were added because of the research (Colson et al., 1986) indicating a difference between professional groups in what clients they perceive as being difficult to work with. The Working with Clients Grid that resulted is found in Appendix A. The triadic elicitation method was employed with it, with the order of the triads being randomly derived. To ensure elicitation of maximally different constructs, as advocated by

Thomas (1979), the 20 grids for each of the groups had different randomised triads. That is, for each group of participants no one grid had the same order of triads but each group received the identical set of grids.

It should be noted here, that supplying the elements for the Repertory Grid may have some methodological problems. Ideally, the participants would have been asked to supply their own clients for the elements in the grid and then their constructs about working with them recorded. However, to assess the commonality of construing within and between groups using the Rep Grid Program (Shaw & Woodward, 1990) the elements were required to be supplied. This procedure could bias the results towards stereotypical responses similar to those found when using standardised questionnaires.

8.3.2 The Interview Questions

The interview schedule consisted of four questions designed by the researcher. It was also used to elicit each participant's construing of their work with successful and not so successful clients. In addition, the questions were designed to elicit what each participant thought influenced how they worked with clients and the role their training had played in this. The design of the first two questions enabled the participant to provide their own "case vignette" on which to base their reflections of their work with these specific clients. Standardised case vignettes were not used because they may have been beyond the participants' range of experience and therefore not useful in eliciting the important constructs for each individual. It was seen as far more useful for the participants to provide their own clients to talk about for the

purpose of this research. These supplied vignettes were not assessed in any way and served as a reference only for the participants. The interview schedule is found in Appendix E.

8.3.3 The Questionnaires Measuring Direction of Interest and Treatment Type

Two standardised questionnaires measuring Direction of Interest and Treatment Type, the Direction of Interest Questionnaire and the Attitude to Treatment Questionnaire (Caine, Wijesinghe, Winter & Smail, 1982) were also completed by the participants.

8.4 THE PROCEDURE

Each participant was required to allocate at least one hour for the purpose of the individual interview and collection of the Repertory Grid data. They were contacted separately by the researcher and an interview time agreed. The interviews were conducted at the participants' place of employment, or, as happened on only three occasions, participants came to the researcher's place of employment. At the beginning of each interview, the participants were given the information sheet and consent form to sign (Appendix B) as well as a number which served to identify to which professional group they belonged. Their age, gender, country of birth and years of experience in mental health were also recorded on a demographic data sheet.

The data collection began with the interview questions. Each participant was given the following instruction prior to the questions followed by the interview schedule (Appendix E).

I would like you to talk freely and for about five minutes on each of the following questions.

These instructions were given to encourage more detailed responses to the questions. If the participants at first only gave short responses, the question was repeated to serve as a prompt and encourage elaboration. This was the only prompt used during the interview sessions. Each interview was recorded with the participants' permission and later transcribed.

Following the interview the participants were given the Working with Clients Grid to complete. This procedure was introduced in the following way:

The Repertory Grid method is designed to give information on the meaning you attribute to working with clients. Down the side of the grid is a list of clients, numbered one to twelve, and on the top a series of sets of three numbers. The numbers relate to the corresponding client in the list. I would like you to consider each of these groups of clients and tell me in what important way working with two of these clients is similar yet different from the third. It does not matter which two of the three you choose.

The constructs were written by the researcher in the left hand side of the construct column. What the participants considered to be the opposite of the construct was written on the right hand side of the column. In this way each participant produced their own constructs to a supplied set of elements. Lastly they were asked to rate each construct on each element, using a 7 point scale with 1

being most like the elicited construct and 7 being most like its contrast. The midpoint was used if the rating of the construct on the element held no meaning for the participant.

At the end of the interview and the Working with Clients Grid, each participant was given the two questionnaires to complete at a time suitable to them. They were supplied with an addressed envelope in which to return the completed questionnaires to the researcher. The questionnaires have standardized instructions for completion on the forms which are self explanatory. There was a 100% return of the completed questionnaires from participants.

8.5 THE DATA ANALYSES

8.5.1 The Construct Content for each of the Professions (Research Questions 1 & 2)

The number and range of constructs obtained from the Working with Clients Grid necessitated the development of a categorisation system. Each professional group provided 240 bi-polar constructs, with a total of 720 constructs being obtained in total. The only categorisation system of sufficient range available (Landfield, 1971), was not considered suitable, because the subject matter here was different professionals' perceptions of their work with clients, rather than with the qualities or characteristics of the clients per se. The categorisation system devised by the author to focus on working with clients appears in Appendix C. A kappa-K coefficient of agreement (Cohen, 1960) of 0.99 was obtained between the coding of the author and of another independent rater, blind to the profession of the participants, using the coding manual in Appendix C. The complete codings of both raters were

used for the purpose of obtaining the co-efficient of agreement. Because the agreement coefficient was high, only the codings of the author were used in the results.

8.5.2 The Usage of Constructs by Each of the Professions (Research Questions 3 & 4)

The Socio Analysis of the Rep Grid Program (Shaw & Woodward, 1990) was used to assess the commonality of the constructions of the research participants. The Rep Grid Program was more comprehensively discussed in section 6.1.1 of this thesis. The Socio Analysis produces a clustering of constructs and the degree of construct matches, obtained from the ratings, for each pair of grids in each group. The Socio Program then computes the construct matching matrix for each of the combined grids and from that matrix selects the highest match of each construct representing the greatest degree of commonality for the professionals in that group. The analysis shows the relationship or functional similarity between the constructs used by the groups by indicating the similarity of ratings on constructs across the rows of the grids, while the columns indicate the similarity of the elements (Shaw, 1981).

8.5.3 Constructs which Each of the Professions used to Describe Success and Failure with Clients, their Personal Values and the Role of their Training (Research Questions 5, 6 & 7)

The interviews were analyzed according to a devised coding system to allow for analysis by the Non-Numerical Unstructured Data Indexing Searching and Theorising (NUDIST) computer program for qualitative data analysis (Richards & Richards, 1991). A

detailed account of the coding system appears in Appendix D. This method was chosen because no previous research has been undertaken to address the questions considered by this research. It has therefore been necessary to devise a method of analysis and coding of the data. In doing so it is important to point out that these categories have been identified through my own interpretation of what the participants have told me. Similarly the organisation of these categories can only be according to what makes the most sense to me about what I have been told. It is therefore important to check that my interpretations are meaningful to another, and the results of this check will be reported at the end of this chapter.

The first two questions asked of the participants encouraged them to talk about a particular client they had worked with, so they could refamiliarise themselves with the contact they had with this person. They were then asked to talk about what they thought were the most important factors accounting for the success and failure they had experienced with these clients. To analyse the content of their responses to these questions, the first part in which they recalled their clients, was treated as preamble, or more specifically as their providing their own case vignette on which to reflect for the important factors in the relationship. For the purpose of scoring, only the important factors accounting for the therapeutic outcome were scored.

The first two questions were then analysed under three broad headings: The first is (1) *professional characteristics*, (2) *client characteristics* and (3) *other factors*. Each of these categories were then further subdivided into more descriptive categories and

each of these large and smaller categories have been assigned a number to allow them to be indexed and analysed by the NUDIST (Richards & Richards, 1991) computer program for qualitative data analysis.

Responses of research participants to the third question, asking the participants more directly about what they thought influenced how they worked with clients, were also scored and indexed according to the above scoring system.

Their responses to the fourth question, asking the participants what role their training had played in how they worked with clients, was scored and indexed using three main categories. These were factors relating specifically to *theoretical and practical training*, an *informal training* category, and the participants' own *personal factors*. In keeping with the coding and indexing system, these categories were also further subdivided and given a number code. The categories and their indexing codes used in this research appear in Figures 1-4.

8.5.4 Non-numerical Unstructured Data Indexing Searching and Theorising (NUDIST) Computer Analysis

The NUDIST computer program was designed for the qualitative analysis of unstructured data of any kind. It uses a tree-structured indexing system to enable concept-building about a particular project. The categories can occur as “nodes” of indexing tree hierarchies. This is diagrammatically represented in Figures 1-4. The program uses numbers that are attached to each category and sub-category. In other words the text is “flagged” so that it can be identified by the computer.

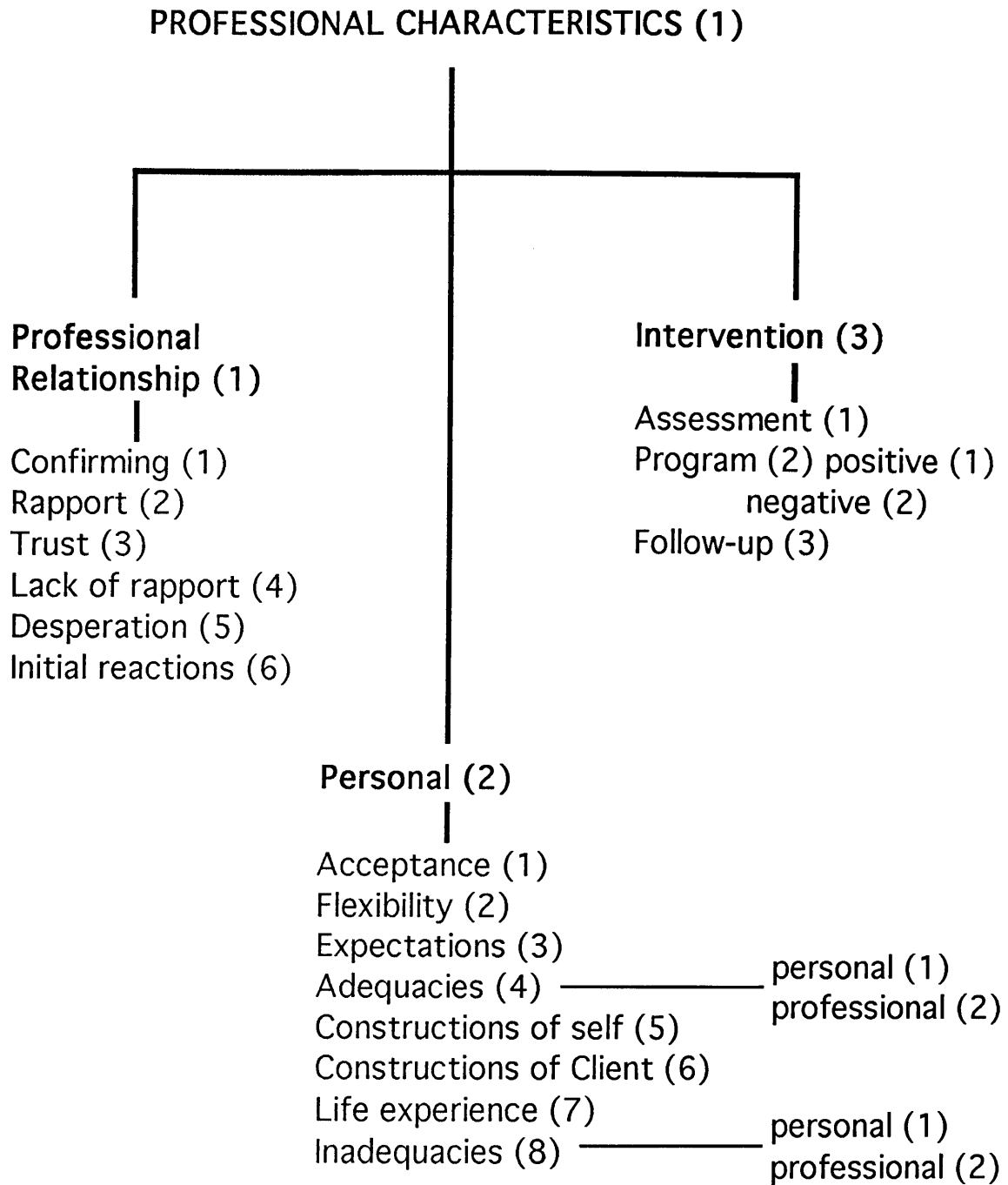


Figure 1
Indexing Codes for the Interview Data-
Major Category of Professional Characteristics

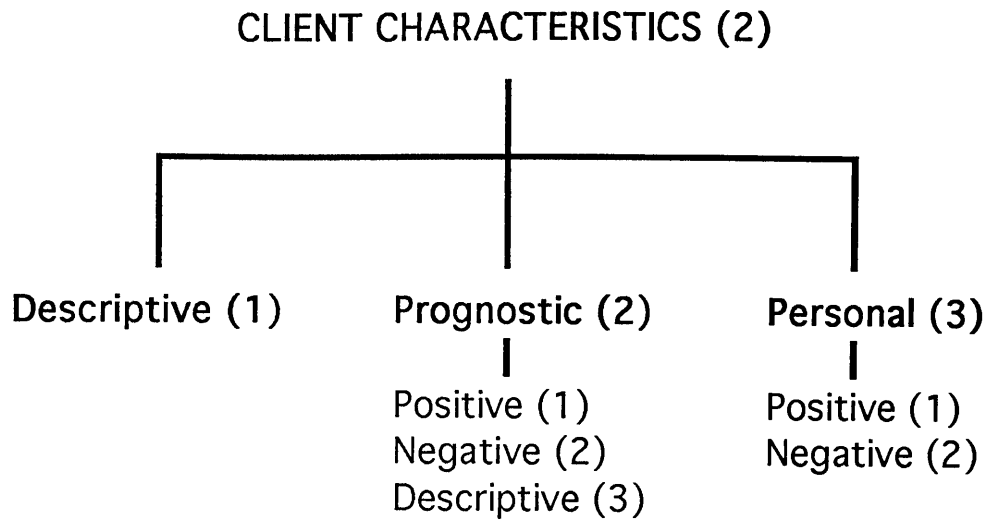


Figure 2
Indexing Codes for the Interview
Data- Major Category of Client
Characteristics

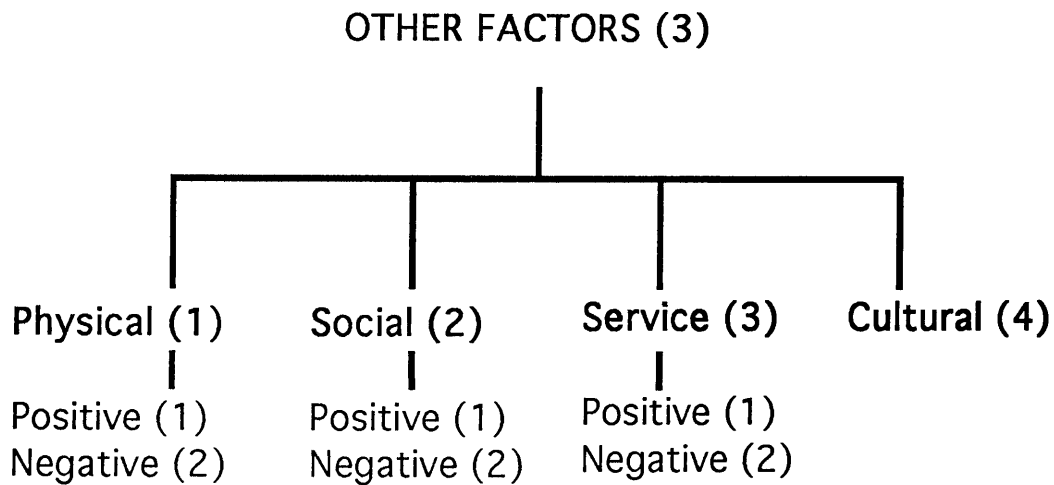


Figure 3
Indexing Codes for the Interview Data-
Major Category of Other Factors

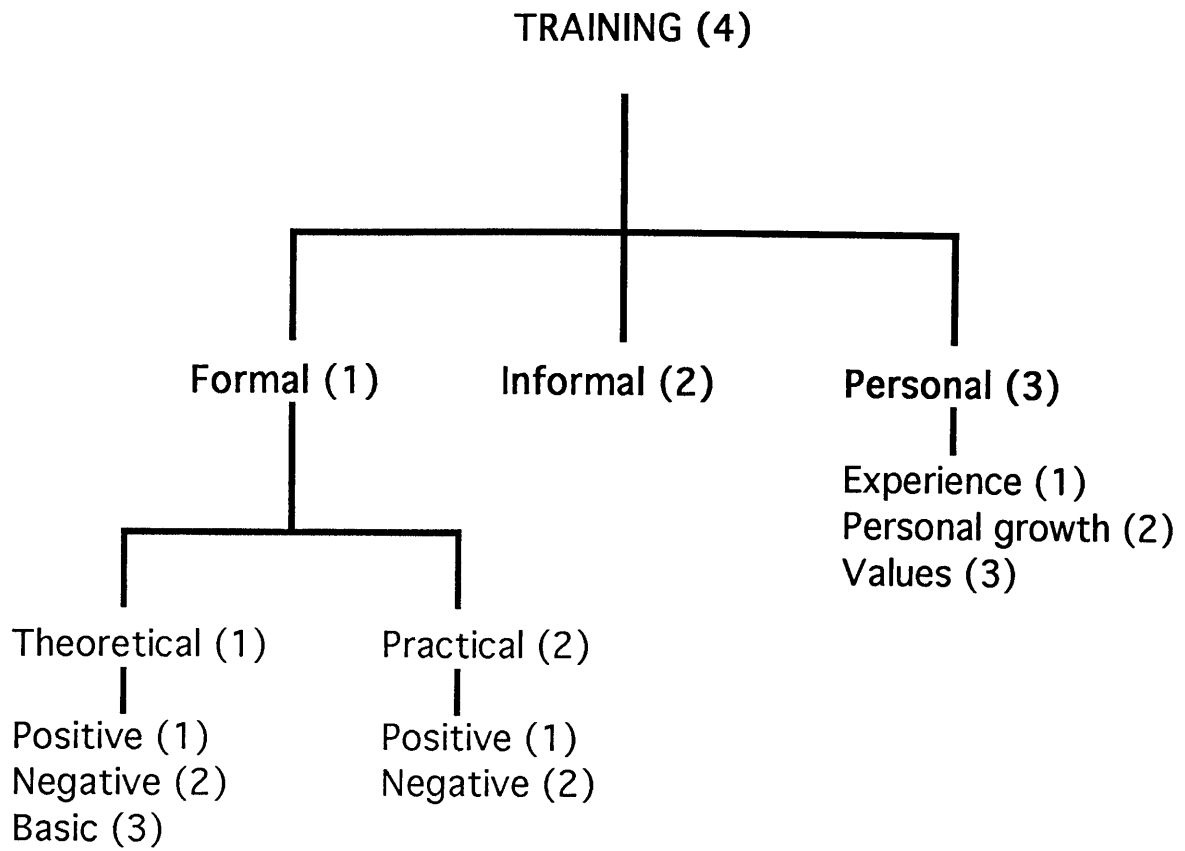


Figure 4
Indexing Code for the Interview Data-
Major Category of Training

8.5.4.1 Numbering of the index codes

Figures 1-4 show the correct number code for each category and subcategory. The first number represents the major category, followed by the next appropriate subcategory and so on down the indexing tree. It is in this sense that the indexing tree is hierarchical in nature. For example this response to Question 1 “The reason I think the therapy was successful was because of the relationship I had with the client and the fact that I validated a lot of their experiences”, would be coded as follows:- professional characteristic / professional relationship / confirming (with a numerical code of 111).

It is important to point out that there is no special relationship between the various categories or the subcategories in the index tree. The NUDIST program was chosen because it goes beyond the “string-search” and “flagging” techniques of content analysis, enabling greater flexibility in the analysis of the data.

8.5.4.2 Reliability of coding

When the agreement between raters for the interview scoring system was examined, a kappa-K coefficient of agreement (Cohen, 1960) of 0.89 was obtained. The scoring was conducted by myself and by an independent judge blind to professional group membership. Again all of the scoring by both raters were used to obtain the co-efficient of agreement. Because the agreement coefficient was high, only the codings of the author were used in the results.

8.5.5 Statistical Procedures

The Statistical Program for the Social Sciences (SPSSX) was used for the statistical analyses of data to determine the matching of each of the groups of participants. For this purpose the ANOVA statistic was used. To determine if the data obtained from the patterns of construct content used by each of the professions were different, the Kruskal-Wallis statistic was used.

Chi-square was used to determine if there was a significant difference between the professional groups in construct usage (Statview 11, 1987). To determine the difference in the patterns of constructs when professionals described their success and/or failure with clients, their personal values and the role of their training in these, chi-square contingency tables were used (Statview 11, 1987).

The ANOVA programme (SPSSX) was used in the analyses of the questionnaire data. The regression analysis was used to determine the degree of relationship between the scores on the DIQ and scores on the ATQ. This was computed, because past research has shown a significant correlation between these two questionnaires.

In the next chapter I shall present the results of the analyses of the data obtained in this research, dealing with each of my research questions in the order it has been presented.

CHAPTER NINE

MENTAL HEALTH PROFESSIONALS' CONSTRUCTIONS OF THEIR CLIENTS

I shall now present some answers to the research questions identified in Chapter Seven. The first section of this chapter, then, will report on the patterns that emerged for each of the professions in the content of their constructions of their work with clients. I shall then report on whether differences existed in these patterns for each of the three mental health professions. The following section will describe what degree of commonality existed within the professions in their usage of these constructs and if the degree of commonality differed between the mental health professions. Next, I shall report on the factors that emerged for each of the professions as their members talked about their work with successful and unsuccessful clients, and if these factors differed for each of the professions. I shall then describe the role of values and professional training as the members of each of the professions identified them in relation to their current practice. The last section of this chapter will deal with the two sets of questions about difference in attitudes to treatment and inner/outer direction of interest.

9.1 THE CONSTRUCT CONTENT OF EACH OF THE MENTAL HEALTH PROFESSIONS (RESEARCH QUESTION 1)

An abbreviated form of the complex categorisation system (Appendix A) used to analyse the patterns of the constructs elicited from the Working with Clients Grids for each professional group appears in Table 2. The emergent pole of the construct (that is, the first description elicited from the participants) was used to determine the category to which each construct belonged. The results from this categorisation of the constructs are presented in Table 3. This table shows the frequently used construct content in

rank order from the most to least used for each of the professions. The criterion employed to determine the most frequently used constructs was to take the the top five subcategories from the

Table 2

Major Construct Content Categories and their Subcategories

Major Category	Subcategory
Client Characteristics	Symptoms
	Reactions to mental health problems
	Stable personality characteristics
	Ability to control behaviour
	Ability to cope
Professional Characteristics	Professional ability
	Professional inability
	Professionals' Feelings of comfort
	Professional relationship
Intervention	Psychologically orientated
	Medically orientated
	Immediate need
	Assessment
	Prognosis

entire categorisation for each of the professions. The top five categories accounted for the majority of the constructs for each of the professions and was therefore considered to be a good representation of the results. Figures 5-7 illustrate the relative frequency with which the three professions use specific construct content.

Table 3
Frequently Used Construct Content in Rank Order from Most to
Least Used for each Professional Group

Psychiatry	Psychology	Nursing
1. Client Symptoms	1. Assessment	1. Client Symptoms
2. Assessment	2. Professional Ability	2. Professional Ability
3. Negative Reactions of Clients	3. Negative Characteristics of Client	3. Assessment
4. Negative Characteristics of Client	4. Symptoms	4. Negative Reactions of Client
5. Professional Ability	5. Cognitive Intervention	5. Negative Characteristics of Client

The psychiatrists proved to be most like the nurses in their use of constructs that refer to client characteristics. This is with the exception of their references to the positive reactions of clients to mental health problems, where psychiatrists are more like psychologists. Psychologists are like nurses in their references to clients' inability to control their behaviour. Differences are however found between the professional groups when referring to therapist characteristics. There are also few differences in the number of references to intervention, with the exception that psychiatrists are more concerned with prognosis and medical intervention, and psychologists with assessment and cognitive intervention.

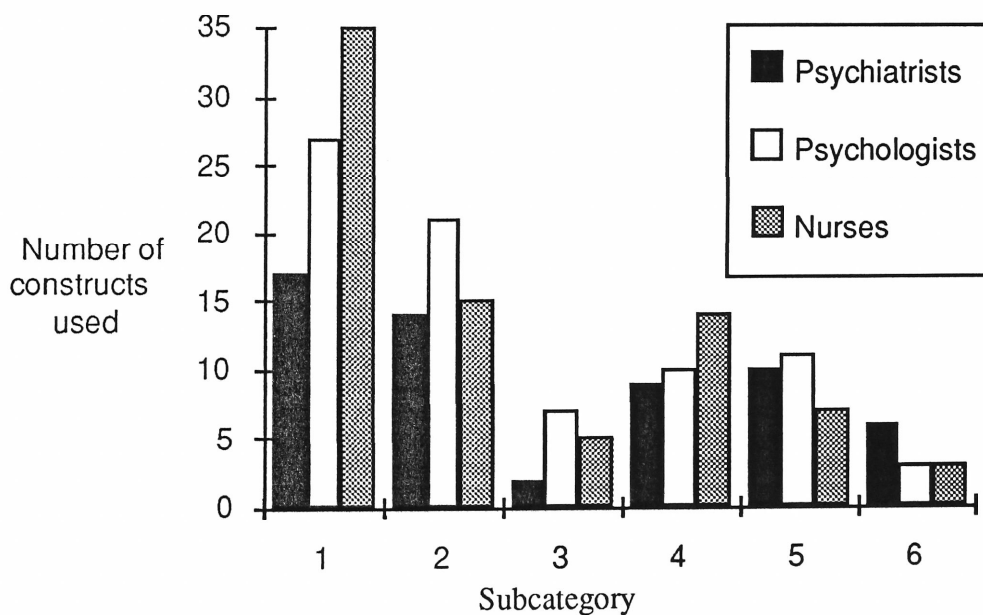


Figure 5. Construct Content Relating to Professionals for each Professional Group.

Note: 1 = professional ability, 2 = inability, 3 = positive feelings, 4 = negative feelings, 5 = positive relationship with client, 6 = negative relationship

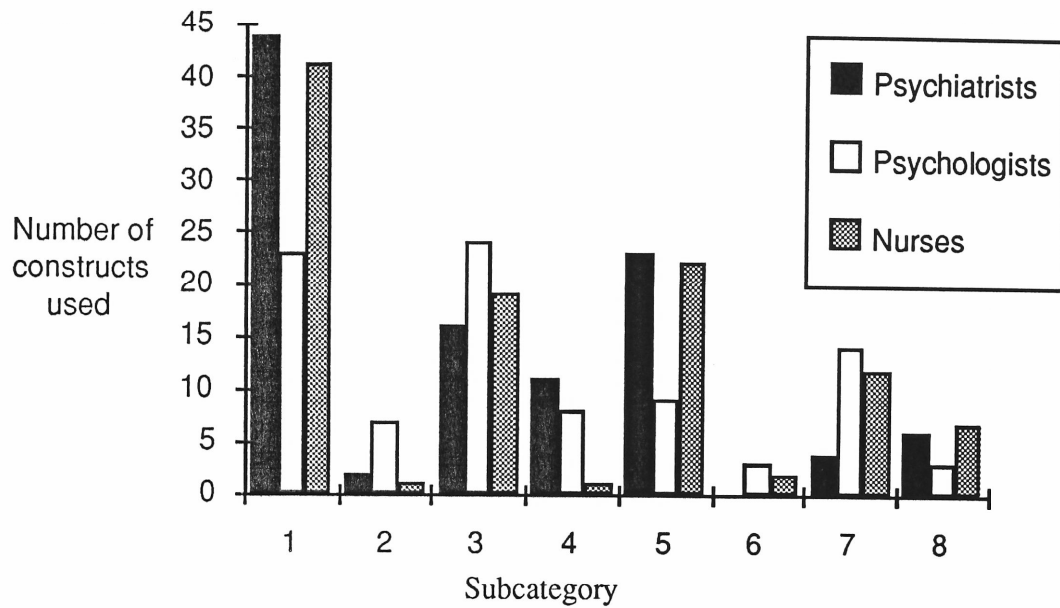


Figure 6. Construct Content Relating to Clients for each Professional Group.

Note: 1 = symptoms, 2 = personality positive, 3 = personality negative, 4 = positive reactions, 5 = negative reactions, 6 = positive control, 7 = negative control, 8 = negative coping

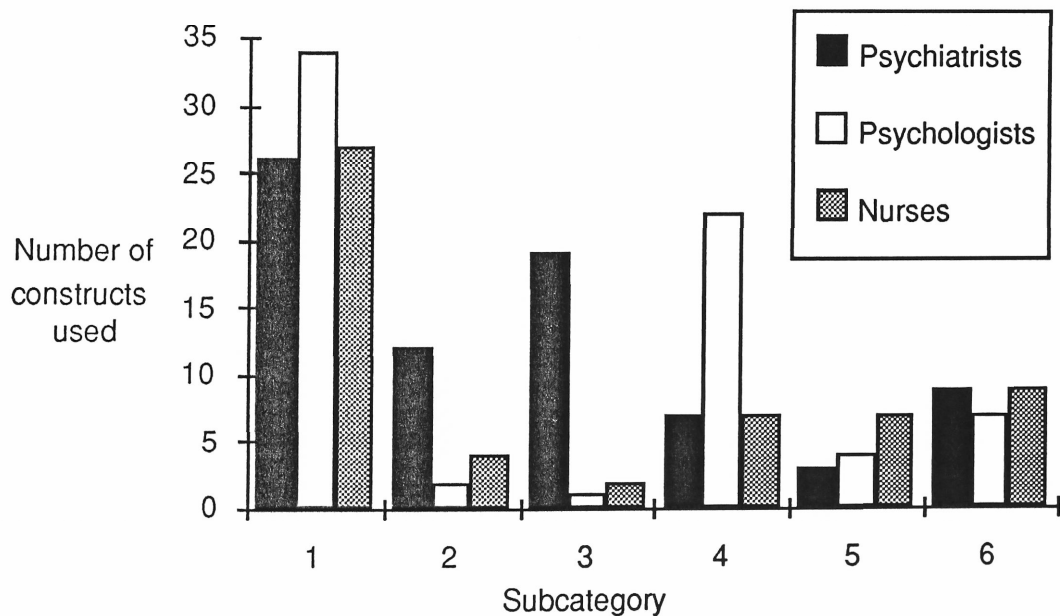


Figure 7. Construct Content Relating to Interventions for each Professional Group

Note: 1 = assessment, 2 = prognosis, 3 = medical, 4 = cognitive, 5 = behavioural, 6 = immediate

9.2 THE DIFFERENCES IN CONSTRUCT CONTENT BETWEEN EACH PROFESSION (RESEARCH QUESTION 2)

No significant differences between the professions in the frequency distributions of their construct content were found by the Kruskal-Wallis test. Although identifiable patterns had emerged in the frequency of use of construct content by each of the professions, the results of statistical analysis indicates that there were no significant differences in the choice of construct content for each of the different professions as assessed by the Working with Clients Grid.

9.3 COMMONALITY IN CONSTRUCT USAGE WITHIN EACH PROFESSION (RESEARCH QUESTION 3)

The way in which the members of each profession uses their constructs about clients was analysed using the Rep Grid Program (Shaw & Woodward, 1990). The usage of constructs provides information on the structure of the participants' construct system and in this way similarities within the entire set of mental health professionals can be determined. It is important to know how each of the professions use their constructs, because it is the usage rather than the content that determines commonality as defined by the Commonality Corollary. The Socio Analysis, then, provided information about the similarities and the contrasts that exists within the entire set of constructs. It does this by comparing the constructs on each grid with those on every other grid. It also provides information on the most closely linked people within each professional group, that is, those members of the groups who use their constructs in similar ways. It is possible to rank order

members of each group from those who are most linked in this way, to those least linked. Another feature of the program is that it provides an analysis of the “mode constructs”, or most shared constructs for the group. These features of the programme were used to explore differences in construct usage by the different professions.

The results of Socio Analysis of the similarities and the contrasts of construct usage for each professional group appear in Table 4. The relatively high percentage of similar construct usage suggests that psychiatrists, as a group, would be more likely to understand the constructions of clients by fellow psychiatrists than would members of the psychologist group whose percentages were lower. However it should be noted that as the degree of similarity, even for the psychiatrist group, is only just above 50%, no more than half of the group would use their constructs in a similar way.

Table 4
Similarities and Contrasts in Construct Usage for each Professional Group

Profession	Percentage of constructs used similarly	Percentage of constructs in contrast
Psychiatrists	53.53	2.85
Psychologists	40.29	4.85
Nurses	52.48	4.63

The number of constructs used differently in the groups indicates the amount to which the members of each group would not be able to understand one another. As Table 4 illustrates, these percentages are very low.

9.4 THE DIFFERENCE IN THE USAGE OF CONSTRUCTS BY EACH PROFESSION (RESEARCH QUESTION 4)

A significant difference between the amount of similarity in construct usage between the psychiatrists and the psychologists (chi-square=197.87, df=2, p<0.001) was, however, found. There was no significant difference in the degree of similarity of construing between the psychiatrist and nurse group.

As the above analysis provided information only on construct usage within each group, it was decided to do the same analysis on a combined sample of grids from each profession. The construct link analysis (described below) was used to select the seven most highly matched participants from each group. This, in essence, provided a model mini-multidisciplinary team. Ideally this information would have been provided using the whole 60 grids. However, the Rep Grid program has only been designed with enough capacity to analyse 20 grids. I was able to analyse 21 grids by abbreviating the the content of the input which allowed the analysis to take place within the confines of the program. The results of this analysis were an overall similarity for the group of 78% and an overall contrast of 2%.

The above results from the 60 grids indicate that while a difference does appear to exist in the way each professional group applies its constructs in its work with clients, this difference is reduced the

more comparisons are made between the groups using the most closely linked individuals who make up that group. What is important then, is not the professional group to which an individual belongs, but rather the degree of commonality of construct usage that exists between the individual mental health professionals involved.

The Construct Link Analysis shows the degree to which each person is able to make the same distinctions as another person, even if they use different terminology. It shows what percentage of matches they have, using an arbitrary cut off point. Because the matching between most participants was reasonably high, for the purpose of this research a cut off point of 85% agreement was used. Analysis of these construct links is graphically demonstrated in Figures 8 to 10 which also show which participants are more likely to understand one another. The analysis also indicated, that of the psychiatrists, 34 links occurred between participants who had at least 50% matching constructs over the 85% cut off point and these were contributed by 17 members of their professional group. For the nurses, 41 links occurred between the participants who had at least 50% matching constructs over the 85% cut off point, contributed by 16 of the nurses. In contrast the psychologists had only 10 links occurring between participants who had at least 50% matching constructs over the 85% cut off, contributed by only 9 participants from this group. This information suggests that there is a higher degree of shared understanding within the Psychiatry and Nursing groups of this research than within the Psychology group.

Construct Links (at least 50% over 85.0)

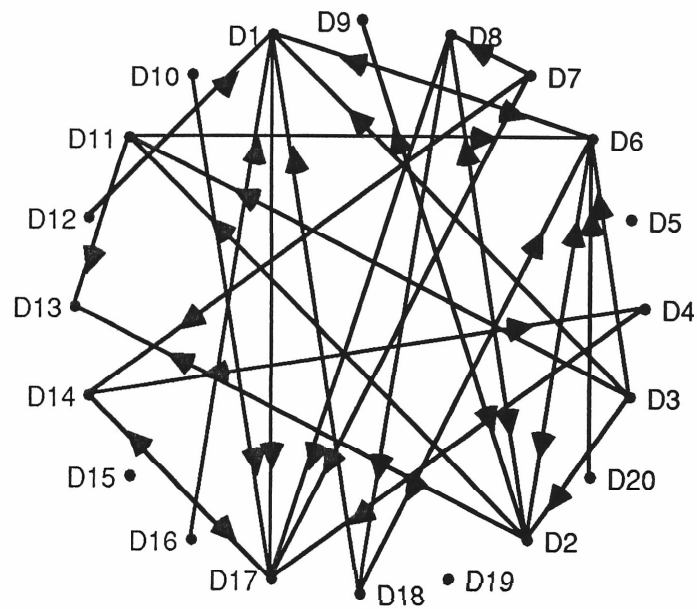


Figure 8
Construct Links within the Psychiatry Sample.

Construct Links (at least 50% over 85.0)

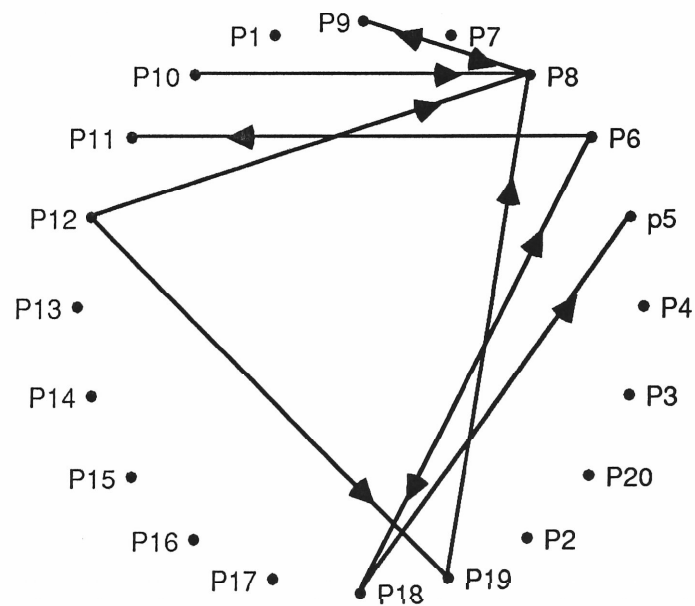


Figure 9
Construct Links within the Psychology Sample

Construct Links (at least 50% over 85.0)

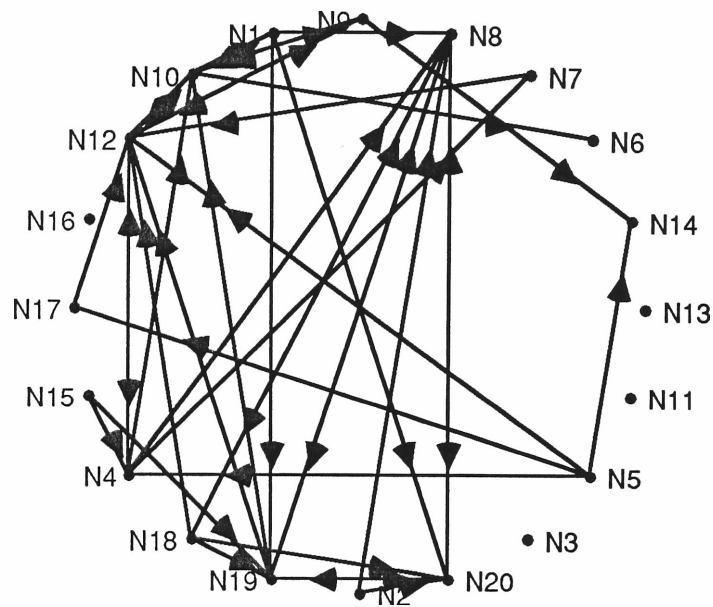


Figure 10
Construct Links within the Nursing Sample.

The calculation of the mode constructs for each group provides a further perspective on the Repertory Grid data from the three professional groups. The mode constructs are those constructs that reflect a consensus in the group, through extracting those constructs which occur as highly matched constructs across the majority of construct systems. An arbitrary cut off point, in this case 90%, was used to select those constructs which reflected consensus within each of the groups. Table 5 illustrates the first five of these mode constructs for each professional group. The table identifies how many of the constructs were accounted for in each of the mode constructs, and the number of people (that is, number of grids) in each group who used this construct. From this table it can be seen that nurses are more likely to share constructs about their work with clients with other nurses, than are the other

professional groups. Their most common construct is used both more frequently by them and by more of them.

In Table 6 I have presented the content of these mode constructs that have been coded according to the system devised for the Repertory Grid constructs. It is important to point out that the mode constructs are derived from the ratings for each of the constructs on the elements. As such, mode constructs reflect the constructs most highly matched in usage, not content.

Table 5
Mode Constructs for each Professional Group in Order of
Agreement

Mode construct	Psychiatrists	Psychologists	Nurses
1.	26 Constructs in 8 Grids	22 Constructs in 9 Grids	69 Constructs in 16 Grids
2.	21 Constructs in 7 Grids	5 Constructs in 4 Grids	12 Constructs in 7 Grids
3.	13 Constructs in 5 Grids	4 Constructs in 4 Grids	3 Constructs in 3 Grids
4.	6 Constructs in 4 Grids	4 Constructs in 3 Grids	4 Constructs in 2 Grids
5.	5 Constructs in 4 Grids	3 Constructs in 3 Grids	3 Constructs in 2 Grids

Table 6
Content of Mode Constructs for each of the Professional Groups

Mode construct	Psychiatrists	Psychologists	Nurses
1.	Client Characteristics	Symptoms and Professional Ability	Professional Ability and Client Characteristics
2.	Symptoms	Assessment	Client Characteristics
3.	Professional Ability	Client Characteristics	Therapist Characteristics
4.	Therapeutic Relationship and Symptoms	Symptoms	Symptoms
5.	Symptoms	Professional Ability	Professional Ability

In Table 6 I show the content of these mode constructs for the purpose of determining those areas of consensus that exist for each of the professions. This is relevant to both my first research question, that patterns of construct content may be identifiable for each profession, and my second question that differences may exist between the professions in these patterns. It should be noted that a comparison with the results summarised in Table 3 of the construct content of the Working with Clients Grid in Section 9.1

of this chapter, with the constructs that are used in similar ways of Table 6, indicates that differences do appear. This suggests that mental health professionals may use similar construct content, but use these constructs in different ways. These results provide only weak support for the expectation that different patterns of construct content and usage would be identified for each of the professions.

9.5 CONSTRUCTIONS OF THE FACTORS ACCOUNTING FOR SUCCESS OR FAILURE WITH CLIENTS FOR EACH PROFESSION (RESEARCH QUESTION 5)

The data from the interview question about success and failure with clients were analysed using the NUDIST computer program. Each interview obtained from the participants was transcribed by the researcher and then coded according to the coding system devised by the researcher (see Appendix D). A summary of this coding system appears in Table 7. Each transcript and their accompanying codes were then processed into the NUDIST program. Additional coding was also added for each participant. This coding identified the “base data” for each person and was coded for in a fifth category. These codes included their profession, age, gender, years of experience and whether they worked in the hospital or community. A sixth category was created in the program that enabled the identification of responses to each of the four questions. The seventh category provided a coding system for scores on the Attitude to Treatment Questionnaire and Direction of Interest Questionnaire. Each respondent was coded according to either their psychological or organic approach to treatment in the case of the ATQ, and for their inner or outer

direction of interest in the case of the DIQ. All of these codings allowed for more complete yet in depth analysis of the major responses and themes obtained from the interviews and other data.

Table 7
Major Categories Describing Responses to Questions about Success or Failure Factors, Values and Training for each Professional's Work with Clients

Major Category	Subcategory
Professional Characteristics	Professional relationship
	Personal
	Intervention
Client Characteristics	Descriptive
	Prognostic
	Personal
Other Factors	Physical
	Social
	Service
	Cultural
Training	Theoretical
	Practical
	Informal
	Personal

The first analysis of the data provided information on how each of the professions responded to the first two questions for the various categories from the coding system. In the case where an individual used a subcategory more than once for each particular question, that subcategory was only scored once. This method allowed for direct comparison across professional groups, as only the number of individuals using the category have been scored. A summary of the information obtained from this analysis for each of the professional groups is presented in Table 8 in a similar format to that of the earlier data. The distribution of the rates of use for these categories for each professional group is presented in Figure 11.

Table 8
Factors that Professionals Describe Relating to their Success/Failure
with Clients in Rank Order for each Group

Psychiatrists	Psychologists	Nurses
1. Professional Relationship	1. Professional Relationship	1. Professional Relationship
2. Intervention	2. Professionals' Personal Characteristics	2. Intervention
3. Professionals' Personal Characteristics	3. Clients' Personal Characteristics	3. Professionals' Personal Characteristics
4. Prognosis	4. Intervention	4. Clients' Personal Characteristics
5. Clients' Personal Characteristics	5 a. Prognosis	5 a. Prognosis
	5 b. Social Factors	5 b. Social Factors

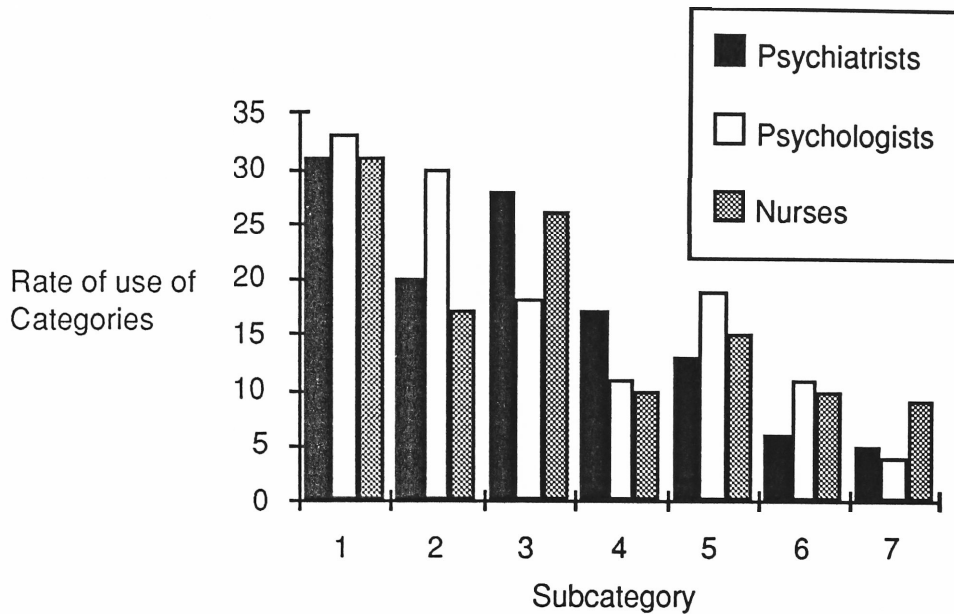


Figure 11. Rate of Use of Influential Factors in Categorising Work with Successful or Unsuccessful Clients for each Professional Group.

Note: 1 = professional relationship, 2 = professional's characteristics, 3 = intervention, 4 = prognosis, 5 = client's characteristics, 6 = social factors, 7 = service.

Overall there were far more similarities amongst the three groups than there were differences. All groups identified the professional relationship as the most important factor accounting for success or failure with clients. Intervention was the second most important factor for the psychiatry group and the nursing group, with the professional's personal characteristics more important for the psychology group. The professional's personal characteristics were the third important factor for the psychiatry and nurse groups, and the client's personal characteristics for the psychology group. These results suggest that psychiatrists and nurses may be slightly more similar in their use of the various categories to describe their work with clients than psychologists are to either of them.

9.6 DIFFERENCES IN THE SUCCESS AND FAILURE FACTORS IDENTIFIED BY EACH OF THE DIFFERENT PROFESSIONS (RESEARCH QUESTION 6)

However, there was no significant difference between the professions in the distribution of these factors in the categories when the Chi-square test was used (chi-square=14.14, df=12, p=.29). Again, although factor patterns were identified for each professional group as influential in their work with successful and unsuccessful clients, statistical analysis indicated that no significant differences exists between these patterns.

9.7 THE ROLE OF VALUES AND PROFESSIONAL TRAINING IN MENTAL HEALTH PROFESSIONALS' CONSTRUCTIONS OF THEIR CLIENTS (RESEARCH QUESTION 7)

The results of the analyses to the responses to the interview questions about the role of personal values in professionals' work with clients are presented in Table 9 and illustrated in Figure 12. An important finding from these interview data has been that, of the total 60 participants, only two referred to their training as an important factor in influencing how they work with clients. This finding was not expected. What did emerge as the most important factor for each of the professions was professionals' personal characteristics, that is who they understand themselves to be as people. When describing the role of these factors, psychiatrists most often referred to constructions they had of themselves, their professional adequacies (but did not mention their training as responsible for these) and their life experience. Psychologists most often referred to acceptance of the client, constructions they had of themselves, their own personal and professional characteristics

(again professional training was not the issue for these respondents). Nurses had a more even distribution of the subcategories, with their acceptance of clients and their life experience being their most frequently identified factors.

Table 9
The Role of Personal Values in Working with Clients Described by
each Professional Group in Order from Most to Least Used

Psychiatrists	Psychologists	Nurses
1. Professionals' Personal Characteristics	1. Professionals' Personal Characteristics	1. Professionals' Personal Characteristics
2. Professional Relationship	2. Professional Relationship	2. Professional Relationship
3. Intervention	3. Intervention	3. Intervention

When the Chi-square test was used, no significant difference between the professions in the distribution of these categories emerged. The role of personal values for each of the professions was therefore judged to be highly similar.

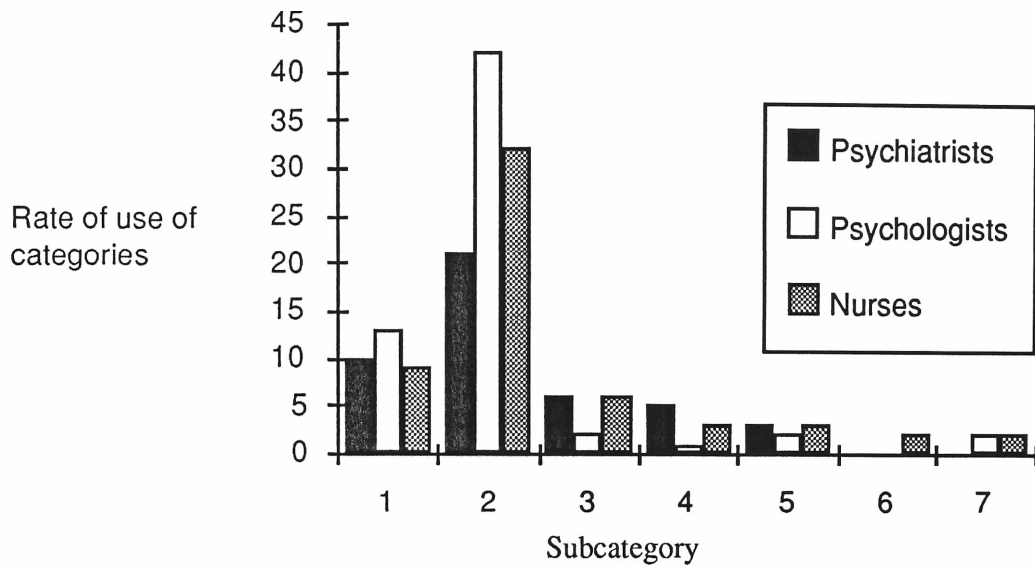


Figure 12. Rate of Use of Influential Factors in Categorising Work with Clients for each Professional Group.

Note: 1 = therapeutic relationship, 2 = therapist's personal character, 3 = intervention, 4 = prognosis, 5 = client's personal character, 6 = negative social factors, 7 = positive service factors.

As I did not obtain the expected results in relation to therapists describing training as an important factor in how they work with clients, I have chosen to present the results to the question relating to the role of their training in a different format. Table 10 presents the number of professionals who responded in each of the categories for this question. The results indicate that overall the respondents viewed their training as more of a negative than positive experience, and that the practical component of that training was viewed more favourably by them than the theoretical component. More than half of the respondents reported their training to be rather basic. These results may in part account for the fact that only two participants reported their training as important in how they work with clients. It is also interesting to note that nearly one third of the psychiatrists reported their

informal discussions with colleagues to be an important part of their training, while nearly one third of psychologists reported on the value of personal growth as a component of training. I must note here, however, that the themes that emerged as important for these professionals when working with clients suggest to me that their training has influenced all of them.

Table 10
Frequency of Responses to the Training Question for each
Professional Group

Category	Subdivision	Psychiatrists	Psychologists	Nurses
Theoretical	Positive	7	7	3
	Negative	9	13	13
	Basic	7	11	11
Practical	Positive	10	10	10
	Negative	1	0	4
Informal		6	4	2
Personal	Experience	1	2	4
	Personal growth	2	6	0
	Values	3	3	4

Again there were no significant differences between the professions in the distribution of the training factors across the

categories when the Chi-square test was used. The minimal role of training reported by each of the professional groups seems highly similar.

I developed a series of propositions about the interview data to determine if certain patterns of responses occurred among the participants. For example, if a respondent used one category, did this mean that they were also likely to use another? This is consistent with the grounded theory on which the NUDIST program is based. It allows for the development of themes from the data. I made many propositions about the data and I have only reported here on those propositions that I considered of direct relevance to my research aim.

Proposition 1 asked: Were those research participants who perceived their theoretical training negatively (35) likely to also report on factors that might be closely linked to their training? The results indicated that not one participant who perceived their theoretical training negatively also responded to questions with factors such as personal inadequacies (37) or professional inadequacies (18). Nor did these participants evaluate their interventions negatively.

Proposition 2 asked: Did participants who described personal inadequacies (37) also describe professional inadequacies (18)? Analysis revealed that only six used both subcategories, indicating that participants were likely to identify either personal or professional inadequacies, but not both.

Proposition 3 asked: Was there a relationship between any of the construct content based on clients' characteristics, and was there a

relationship between the use of these and any other category? Of the participants who described negative prognosis (27) and negative client characteristics (30), only 11 participants used both these categories to account for lack of success. There is some evidence that prognosis may be viewed by these mental health professionals independently of other client characteristics. Also, those participants (25) who reported the client to have positive personal characteristics were not the participants who also reported acceptance of the client (30), indicating that acceptance of the client may not necessarily be related to a positive attitude about the client.

Proposition 4 asked: Did participants who described clients as having good prognosis also refer to the importance of a good program of intervention for them? Analysis of the responses coded for positive prognosis (9) indicated of those participants who described it as important, 6 of them also reported the program of intervention to also be positive (out of a total of 53). Professionals may view a client's prognosis more positively if they see them as responding to their program of intervention.

Proposition 5 asked: When professionals describe lack of success with their clients, is there a relationship between client characteristics and social or mental health service factors? Little relationship was found between use of these categories. Of the participants who described the negative prognosis of a client (31) and those who described negative social factors for the client (21), only 8 of these used both of these categories. Of the participants who described negative characteristics of the client (30) and those who described the negative social factors of the client (21), only 7

participants used both of these categories. Of those participants who described the clients' negative prognosis (31) and those who described negative health service factors (17), only 7 used both categories. Of those participants who described the client as having negative personal characteristics (30) and those who described negative health service factors (17), only 7 used both of these categories.

These findings also suggest that these mental health professionals viewed their clients' prognosis as independent of other factors. A poor prognosis was not commonly identified as important in success or failure, together with a client's poor social network or with poor health service factors. Negative characteristics of the client were also not frequently used together with descriptions of the client's poor social network.

The NUDIST computer program allows for, and encourages, many propositions to be asked of the data. It provided an opportunity to ask questions of the participants' responses to the interview data, as well as to ask the data if some relationship existed between these responses and their responses to each of the questionnaires. Proposition 6 therefore asked: Will the participants' score on the Direction of Interest Questionnaire (DIQ) and the Attitude to Treatment Questionnaire (ATQ) indicate their likely responses on the most frequently used categories from the interview data? Table 11 shows the most frequently used categories across all questions by the respondents and how these correspond to their scores on the DIQ and the ATQ. Inner direction of interest was allocated to those participants who obtained a score on the Direction of Interest Questionnaire of 15 or above, and outer direction of

interest was allocated to participants who obtained a score of 14 or below. Similarly, a psychological approach to treatment was allocated to those participants who obtained a score of 50 or below on the Attitude to Treatment Questionnaire, and an organic approach to treatment was allocated to participants who obtained a score of 51 or higher on this questionnaire. The decision to make these cut-off levels was

Table 11
Percentage of Respondents Using Each Category According to their
Inner or Outer Direction of Interest and their Psychological or
Organic Approach to Treatment

Category	Inner Direction of Interest	Outer Direction of Interest	Psychological Approach to Treatment	Organic Approach to Treatment
Confirming	4 7	1 8	5 3	1 8
Rapport	7 9	6 4	7 5	7 1
Desperation	4 7	3 2	4 7	3 6
Program Positive	7 4	9 4	9 1	8 6
Personal Inadequacy	4 2	9	3 4	2 5
Professional Inadequacy	3 9	1 8	4 1	2 1
Program Negative	2 6	2 7	2 5	2 9
Acceptance	6 1	3 2	5 3	4 6
Client Positive	4 5	3 2	4 4	3 6
Personal Values	2 1	9	2 2	1 1
Theoretical Positive	3 2	2 3	3 4	2 1
Theoretical Negative	6 3	5	6 8	4 6
Practical Positive	5 0	5 0	5 0	5 0

based on the work of Caine, Wijesinghe & Winter (1981).

A significant difference was found for both of the questionnaire-based categories and the most frequently used interview-based categories using the Chi-square statistic. The inner and outer directed professionals showed a significant difference in category frequency (chi-square= 75.33, df=12, p=.0001). The psychologically and organically minded professionals also showed a significant difference in these categories (chi-square=22.16, df=12, p=.04).

These results indicate that participants who could be described as having an inner direction of interest and a psychological approach to treatment are more likely to: use constructs that relate to the confirming nature of their relationship with their clients; are more likely to refer to their personal and professional inadequacies; are more likely to report acceptance of their clients and view them in a positive way; are more likely to refer to their personal values with their work with clients; and are much more likely to refer to their theoretical training negatively.

In contrast those participants who have an outer direction of interest are more likely to refer to the program of intervention positively with their work with clients. It is interesting to note that for this category the program was not viewed more favourably by those participants who had an organic approach to treatment. The participants appear fairly similar in their responses to the negative aspects of their programmes of interventions and the practical aspects of their professional training. It is also interesting to note that the DIQ, measuring direction of interest, showed a greater power to differentiate between the participants' use of the coding categories.

9.8 THE INNER OR OUTER DIRECTION OF INTEREST OF EACH PROFESSION (RESEARCH QUESTION 8)

For the Direction of Interest Questionnaire an Analysis of Covariance (ANCOVA) with profession as the group factor and a set of biographic variables as covariates on its scores, showed no significant differences. The biographic variables tested were gender, years of experience and place of employment. Place of employment was identified as the respondents' primary place of work with their clients. If the respondents worked in both the Hospital and Community setting, the greater time spent in the setting determined place of employment. More than 75% of the respondents' time was found to be spent in either one or the other services. The lack of group difference is confirmed by the means and standard deviations in Table 12, showing no differences on the Direction of Interest Questionnaire between the professions. However, although not significant, the scores differ in the direction anticipated. This and the finding that there was no difference between professionals working in different treatment settings is also inconsistent with the work of others cited elsewhere.

Table 12.

Means and Standard Deviations of the Direction of Interest Questionnaire Scores for each Professional Group

Profession	n	Mean	sd
Psychiatry	20	15.85	6.45
Psychology	20	19.55	5.88
Nursing	20	16.7	6.42

9.9 TAKING THE PSYCHOLOGICAL OR ORGANIC APPROACH TO TREATMENT FOR EACH PROFESSION (RESEARCH QUESTION 9)

To determine if there were significant differences in the Attitude to Treatment Questionnaire scores between the three different mental health professional groups, another (ANCOVA) was conducted. The scores of the dependent variable, Attitude to Treatment Questionnaire, were entered with the group factor of profession and covariates of gender and years of experience to determine their effects. The only variable that showed a significant effect was profession ($F=6.38$, $df=2$, $p=0.003$), indicating that the Attitude to Treatment Questionnaire responses are not influenced by gender or years of experience, but that they are influenced by profession. To determine where the significant effect lay between professional groups, a posteriori contrasts (the Scheffe test) were conducted. A significant difference ($F=6.47$, $df=2$, $p=.01$) was found between the psychiatrists ($\bar{X}=53.10$, $SD=6.03$) and psychologists ($\bar{X}=44.75$, $SD=7.54$) only. The psychiatry sample was more organic in their approach to treatment, while the psychology sample was more psychological. The nursing sample was not significantly different from the other two samples, although they could be described as generally more organic in their approach to treatment and closer to the psychiatry sample.

Table 13.

Means and Standard Deviations of the Attitude to Treatment Questionnaire Scores for each Professional Group.

Profession	n	Mean	sd
Psychiatry	20	53.1	6.03
Psychology	20	44.75	7.54
Nursing	20	50.75	8.88

A separate analysis was carried out to determine if place of employment, as shown by Winter et al. (1985), produced a significant difference on the Attitude to Treatment Questionnaire. Another analysis of variance (ANOVA) was conducted. The psychologist group was unrepresentative of the larger sample, because only one respondent worked in a hospital setting. The other two groups were more evenly distributed in their place of employment, so that only these two groups were used in the analyses. This procedure was carried out because this sample group (that is, the psychiatrists and nurses) were not significantly different on responses to the Attitude to Treatment Questionnaire when analysed according to profession. ANOVA showed no significant difference due to place of employment. This result is in contrast to those found by other authors.

Regression analysis was conducted to determine if a relationship existed between the Direction of Interest Questionnaire and the Attitude to Treatment Questionnaire. A significant regression coefficient was obtained ($R=.38$, $p<0.001$, $SE=5.59$). This finding

is consistent with those obtained by Caine et al. (1981) and Winter (1985) regarding the relationship between the two scales.

In the next chapter I shall summarize the answers to my research questions and discuss the implications of my research findings for professional practice and training.

CHAPTER TEN

THE IMPLICATIONS OF THE RESEARCH FOR MENTAL HEALTH SERVICE DELIVERY AND PROFESSIONAL TRAINING

In the final chapter of this thesis I shall focus on the findings of my research on mental health professionals' constructions of their clients. I shall ask whether I have answered my research questions and how well. I then discuss the practical and theoretical implications of this research as well as some ideas for future research in this area. First, I shall briefly present some of the important points from the introductory chapters of this research report that have shaped the meanings I have attributed to my own research.

10.1 A SUMMARY OF THE RESEARCH BACKGROUND

The aim of this research has been to understand better how the members of three mental health professions make sense of their work with clients. I have chosen personal construct theory to be the guiding framework for my data collection because it has been the most useful for me in this endeavour. Consistent with this approach I have fully described my role in the research process. I shall now present the most important of the findings from the many avenues in this search for understanding how each of the professions are similar yet different from the others, and what role their values and training have played in this.

The first issue to arise in examining the broad context of mental health service provision is that there is much confusion and uncertainty amongst professionals about what is expected of them and what their roles are in the current mental health system. This uncertainty appears to pervade policy makers and administrators because their plans for better mental health services have been less than successfully implemented. There appears to be no overall

framework that is able to provide meaning for the complexity of problems involved in the many components of the mental health service. Each professional group seems to be working in isolation to meet their own ends. Not only are the clients the casualties of such a situation but so too are the professionals in the service.

At this time of uncertainty, mental health professionals appear to be searching for sources of validity for their work. One way of achieving this is to emphasize their uniqueness. Yet the research evidence suggests that no one profession is any more successful in promoting mental health outcomes than the others. Professionals' constructions of their work appear to be influenced by service factors, what is expected of them in their role and most importantly by their values and beliefs that they held prior to their professional training.

Yet the training of mental health professionals has been identified as one of the main reasons that the new approaches to mental health care services have been unsuccessful. The study of the role of training in the development of professionals is complex. There is no guarantee that even training in one profession will deliver the same professional values to everyone. There is also little rigorous research on this topic but many assumptions made about the way professionals make sense of their work with clients.

Personal construct theory is very useful for understanding this complex situation. From this approach I would argue that each profession and probably the many other components of the mental health system have their own culture. Each searching for their own meanings. When the individuals, or the culture to which they belong, anticipate events that are contrary to those expected, many

emotions arise. I would also argue that such a situation would lead to the “closing of ranks” and retreat to entrenched positions. However, I have also argued that these boundaries may be artificial. It was this position that led me to test my “hypotheses” of the similarity and difference between mental health professionals in how they make sense of their work with clients. I shall now present a summary of my research findings.

10.2 A SUMMARY OF MY RESEARCH FINDINGS: HOW MENTAL HEALTH PROFESSIONALS MAKE SENSE OF THEIR CLIENTS

10.2.1 The Patterns of Construct Content Used by Each Professional Group

Initially I asked whether there were patterns of construct content identifiable for each of the three professional groups as measured by the Working with Clients Grid. The results indicated that patterns could be identified for each of the professions. The psychiatry group seemed most like the nursing group in the content of the constructs they used. The psychiatry group primarily used constructs that referred to client symptoms and assessment of the client. This finding is consistent with the research that suggests that the profession of psychiatry is becoming increasingly biological in their approach to their work. Symptoms and assessment are the hallmark of the medical model. Similarly the nursing group used construct content that referred to client symptoms, followed by their own professional ability then by client assessment. They seem to be following a medical model in their work with clients. Their more common use of constructs that relate to professional ability may in part be in response to their need for validation from the mental health services in which they

work. These results indicate to me that there is a need for them to communicate their effectiveness with clients in a difficult working environment where little validation is obtained. Clients do not improve greatly and the medical profession is still dominant and asserting more control over the other professions, as a result of the professionalisation process that I have mentioned. The psychology group were concerned with their own professional ability, second only to client assessment, probably for the same reasons. The use of assessment by the psychology group is not surprising as assessment is portrayed as a primary role of psychologists in these services. These findings support the argument that training does socialize trainees into what is expected of them in their role. However, these results may also indicate that stereotypical responses have occurred because the elements in the Repertory Grid were supplied. This is a methodological problem for researchers who are interested in assessing commonality within and between groups of people because of the limitations of the analysis of such information.

It is noteworthy that all three professional groups focused frequently on either the negative characteristics of clients or the negative reactions of clients to their problems. Such responses may be due to the inability of professionals to obtain the success they hope for in their work with clients. The "kick the cat" syndrome in mental health professionals has already been identified in section 3.3 of the literature review; and I believe it is again an indication of the great difficulties that professionals are faced with in their day to day work. Further, to look inwards at their own role with clients, I believe, could provide more invalidation of their construing of their work than they would comfortably be able to manage. This

observation is supported by their far greater use of constructs that refer to their professional ability than inability. I also found it interesting that the psychologists were the only group not to refer to the negative reactions of clients. I believe that the training of psychologists would more likely emphasise that negative client reactions would be understandable in certain situations. It seems likely that these patterns of construct content are due to the training of professionals but also to their work setting in part.

10.2.2 The Lack of Differences between Each of the Professions in their Construct Content

I then tested whether the patterns of construct content that emerged for each profession were different from one another. The statistical analysis indicated that there were no significant differences between the three professional groups. That is, although the content of the constructs used by the three professional groups showed identifiable patterns, these patterns are not significantly different from one another in terms of frequency of reporting. Members of these three mental health professional groups appear to be more similar in construct content than they are different when they describe their work with clients.

Another possible interpretation for the above results is of course that the Kruskal-Wallis test lacked the statistical power to detect the differences that may have existed. However, this test has been shown to be almost as powerful as the F-test in the analysis of variance (Roscoe, 1975) further decreasing the likelihood of a Type II error having been made, although this can never be ruled out.

10.2.3 How Each of the Professions Use their Constructs to Describe their Work with Clients

Constructivists would argue that, not only is the content of the constructs used important, but the structure of the construct system is more so. That is, it is important to determine the ways in which constructs are used. The verbal labels of the constructs may not be the same, but if they are used in a similar way, then commonality or similarity of construing is likely to be able to occur and communication will be possible. Data analyses indicated that the psychiatry group were, because of the way they applied their constructs, more likely than the psychology group to understand one another's construing of their work with clients. In fact only half of the most similar group would be able to understand one another's usage of constructs. These results may fit with the suggestion that the structure of the construct system that professionals use to describe their work with clients is poor (Agnew & Bannister, 1973).

Statistical analysis indicated a significant difference between the psychiatry group and the psychology group in the similarity of their usage of their constructs to describe their work with clients, with the psychiatry group showing the greater degree of similarity. The nursing group, while close to the psychiatry group was not significantly different in its construct usage from the psychology group. However, an interesting finding was that if the most closely linked members of each group were put together to form a model pseudo-multidisciplinary team, then the similarity of usage of their constructs reached a much higher level. I believe these results suggest that commonality of construing transcends professional

boundaries. This finding is in agreement with research cited earlier that suggests that it is the ability of the individuals in the team to understand one another that is important and not the profession to which they belong. It is maybe who we are as people that is more important than the profession to which we belong.

10.2.4 How Each of the Professions Describe Success and Failure in their Work with Clients

Interview methodology was used to add rigour to the research and supplement the information from the Working with Clients Grid. The interviews were able to obtain from each professional group what they thought were influential factors in their success and failure with clients. To date such questions have been addressed by client reports or questionnaires, while professionals themselves have not been asked. The aim here was to determine if patterns could be identified for each of the professions in their success and failure with clients. Again the responses to the interview question of the psychiatry group were most similar to the responses of the nursing group; however, overall there appeared far more similarity amongst the three groups than there were differences. All groups identified the professional relationship as the most important factor accounting for success or failure with clients. Intervention was the second most important factor for the psychiatry group and the nursing group, with the professional's personal characteristics more important than that for the psychology group. I would argue that these patterns again provide a reflection of the training for each group.

Statistical analysis of the above results showed no difference between the professional groups in the frequency of their

responses to influential factors accounting for success or failure with clients. Again it would appear that these three professions are more similar than they are different from one another. The responses obtained from these professionals fit with the factors that have been reported to account for success or failure with clients in the research literature.

However, it should be noted that there were slightly different patterns of responses for each of the professions. Therefore the chi-square statistic may have failed to detect any differences between groups because of the lack of statistical power of this test.

10.2.5 How Each of the Professions Describes the Role of Values and Training in their Work with Clients

The participants were asked what role their personal values played in their work with clients. The somewhat surprising result was that professionals did not view their training as an important factor that attributed to their work with clients. This finding supports my argument that it is who professionals see themselves as as people that is important in how they make sense of their work. It would appear that when these mental health professionals are asked specific questions about their work with clients, such as was measured by the Working with Clients Grid, or asked about success or failure with clients, then they tap into what appears to be a subsystem of constructs that they obtained from their training. This finding also partly supports those of other constructivist researchers who have identified roles of the professional as some of their most robust constructs. This subsystem of constructs may be poorly structured.

However, when these professionals are asked about their own personal values and about their training in their work with clients, then the results are quite different. They do not talk about their professional roles, but refer to their own personal characteristics. There may be two systems of constructs that professionals use to describe their work with clients; one that relates to their professional role, and one that taps into the professionals' constructs about themselves. Again no significant differences were found between the three groups. In fact, their comments on the role of their personal values in their work were more similar than for any other area explored with them.

That hardly any of the 60 respondents reported training to be an influential factor in how they think about their clients, is disconcerting and needs careful consideration. It should be remembered that more than half of the respondents viewed their theoretical training as a negative experience, and only practical training was viewed somewhat more favourably. Yet, for each of the professional groups, it was professional relationships that they believed to be the most important influence on how they think about clients, but none of the respondents referred to these relationships as being part of their training. Because I conducted the interviews, I can provide some additional information relevant to this issue. When the respondents spoke of their training, the initial comments were typically about the "basic nature" of the training in preparing them for the work they were required to do and that their training was a rather negative experience. When they spoke about the positive aspects of their training, this was typically at the end of the interview and most often expressed along the lines that "it must have been important, I suppose I am not being

fair, it did provide me with quite useful information". The most plausible explanation for me is that mental health professionals have not been trained in ways that allow them to function effectively with those clients who have the more serious mental health problems in the new treatment settings. This is consistent with the research in this area presented in Chapter 4. Another possibility, I would argue, is that training programs may be set up primarily to meet the criteria laid down by each professional group. As I have stated elsewhere, the process of professionalisation and the increasing push for specialisation make this so. It may be that not only is training moving the professional further away from the world view of the client, it may be removing the professional further away from their profession. That is the increasing specialisation is not meeting the needs of the trainee. It is interesting that the respondents did report their life experiences as important in training. A constructivist approach would incorporate personal experience in a training program because such training is seen as encouraging personal experimentation based on past experience. Personal growth would be a desired outcome of training. The psychologists were the group that most frequently reported this, a finding that would be expected for this profession. Again the role of training was described similarly for each of the professions.

Again, the theme that training seems to be remote from how professionals make sense of their work with clients is found from the data that revealed that personal or professional inadequacies and poor program of intervention, were not related to viewing their training as a negative experience. It is interesting that the professionals are not relating these experiences to their training

and that these professionals typically used one or the other category and usually not both. However the respondents were more likely to refer to the positive prognosis of the client, if the client responded to the professional's program of intervention. As George Kelly observed we spend a long time hoarding facts and to see them invalidated would have serious consequences for the professionals. I believe this was evidenced in their responses to the interview question relating to their training. They needed to defend their training to alleviate the emotions that would occur if they did not.

10.2.6 Additional Observations from the Professionals' Descriptions of their Work with Clients

The interview data revealed other interesting findings. For example all of these mental health professionals view the client's prognosis independently of other client characteristics. These professionals also indicated that acceptance of their clients was not related to viewing the characteristics of the client in a positive manner. The professionals also appeared to view the client in isolation from factors such as social support and health care services. This finding I believe indicates that these mental health professionals may still be viewing their clients in isolation from the larger networks of which they are a part. I have shown elsewhere how the community-based mental health care movement argues that the community is the client and discourages viewing the client in isolation. These findings lend some support to the argument that professionals are not adequately trained for the work they are now required to do.

10.2.7 The Inner or Outer Direction of Interest of Each of the Professions

The Direction of Interest Questionnaire (DIQ) scores showed no significant differences in inner and outer directedness between professions, nor could its scores indicate whether these professionals were hospital or community-based. These results are not consistent with the well-replicated results of its application in other studies. These mental health professionals may have a more inner direction of interest than other groups. This may be in part due to the fact that the health care regions from which my sample were drawn do not have any large inpatient treatment centres, although many of the psychiatrists and nurses would have trained in such centres. It could well be that the professionals in this region are attracted to the smaller treatment settings that tend to afford a more psychological approach to treatment. Of course another possible explanation concerns its applicability in a culture different from that within which it was developed. This explanation is supported by the research of Tooth & Stanton (submitted for publication) that was reported in section 5.6 of this thesis.

10.2.8 The Psychological or Organic Approach to Treatment of Each Profession

The results of the statistical analysis of professional differences in scores on the Attitude to Treatment Questionnaire (ATQ) are consistent with those in the literature. The psychiatrists were significantly more organic in their approach to treatment than were the psychologists, with the nurses falling in between these two groups, but being more similar to the psychiatrists. That a parallel analysis using the respondents' work setting yielded no

significant differences could be attributed again to the nature of the mental health services in these regions or to the small sample size. The concern of each profession trying to emphasize its own uniqueness could have influenced the responses to this questionnaire.

10.2.9 Additional Comments on the Use of the Questionnaire Data

The most interesting finding concerning the questionnaire data is that when all of the responses to the interview questions were examined to determine if certain types of responses were more likely for the participants according to the scores on either scale, a significant difference was found for both questionnaires. The scores of both the questionnaires discriminated between the type of responses that participants gave. Professionals with an inner direction of interest and a psychological approach to treatment were more likely to use constructs that refer to the confirming nature of the therapeutic relationship with their clients; were more likely to refer to both their personal and professional inadequacies; were more likely to accept clients and view them in a positive way; were more likely to refer to their personal values in their work with their clients; and much more likely to view their theoretical training negatively.

In contrast those participants who have an outer direction of interest were more likely to refer to the program of intervention positively. It is interesting to note that the DIQ had more power to differentiate between the participants on their responses to various categories. This finding supports Winter's (1985) position that there is "one basic dimension concerning the extent to which an

individual's construing is dominated by awareness of their internal or their external reality" (p.130).

10.3 EVALUATION OF THE RESEARCH

My aim was to understand better mental health professionals' constructions of their clients. The research questions proposed in this research have been at least answered and some useful information obtained as a result. The issue of whether the proposed questions could have been better answered in other ways and how the research could have been improved, will now be discussed. The Working with Clients Grid was shown to be useful and enabled the professionals to make distinctions about their clients. This tool should prove useful for others who wish to explore the distinctions that professionals make about their work with clients. It does provide valuable information about the construct content and use when professionals describe their work with clients.

The use of interview methodology to support the Working with Clients Grid data, I believe, has been a worthwhile exercise and provides promise for constructivist researchers looking for methodologies that are more enabling and expansive. For the interview methods to be more useful I would suggest that in the future the intensive work needed to devise the categorisation and coding systems should be undertaken by a group of researchers who are involved in the research. This procedure would allow for greater consensus about the data and minimise the bias that could occur with just one researcher.

It may also have been that the questions that I asked of the participants were too directive. More open-ended questions about their work with clients may have produced different results. Otherwise I believe the research has been of some use in understanding how mental health professionals make sense of their work with clients, how similar they are in their constructions of clients and what role their values and training play in these. The research has also indicated that certain questionnaires may provide useful information about the construing of professionals and may supplement constructivist research.

Although this research has provided useful information there are ways in which it could have been improved, given more time and resources. The sample sizes for each of the professions were limited by the resources of my negligible graduate student budget. Larger, stratified samples drawn from a more diverse cross-section across Australia may have provided different results, and would have provided opportunities to examine state and city-country differences. Also, although I have argued that my admittedly small samples could constitute a representative sample from which to generalise to all mental health professionals, such an argument may not be valid. Past research has consistently found the variables of age, gender and years of experience not to be significant in the outcome of research findings. This, however, may not be so for the questions I have asked in this research.

10.4 THE THEORETICAL IMPLICATIONS OF THE RESEARCH FINDINGS

This research has demonstrated the value of personal construct theory in understanding some of the many facets of mental health service delivery and the role of the professional in this process.

The theory can account for many of the contradictory findings from the reported data analyses. The methodology generated by the theory, the Working with Clients Grid, has also been shown to be useful in providing insights into the sense professionals make of their work with clients.

The findings of the research are also in agreement with those of others (Philip & McCulloch, 1968; Tully, 1976; Soldz, 1989) who theorise that mental health professionals have separate construct systems for clients. In this research certain types of attributes, such as symptomatology and reactions to their problems, have been assigned to clients, probably as a function of the separate construct system.

The use of questionnaires in this research has however raised some troubling theoretical questions. Generally the findings from their use have not been in line with the well-replicated research of others. Traditionally questionnaires have not been favoured by those using a constructivist approach, so that finding is not incompatible with this theoretical orientation. However, the participants' responses to the questionnaires did have some discriminative power in determining their responses to the interview questions. As I have noted my results do lend support to the position of Rowe (1982) and Winter (1985) that there is a basic dimension of internal or external reality that dominates an individual's construing. Such a position does have theoretical implications for constructivists. Kelly (1955) in contrast observed: "Some writers have considered it advisable to try to distinguish between "external" events and "internal" events. In our system there is no particular need for making this kind of distinction"

(p.55). This issue is one that needs further consideration by constructivists, but to provide such consideration here is beyond the scope of this thesis.

The richness of the information I gained from these mental health professionals causes me to agree with Winter (1985) that the theory provides a unique integrating framework for mental health service provision by being able to accommodate the different approaches of professionals into an eclectic service model. I have provided other examples too, to illustrate the usefulness of the theory in relation to the work of the professionals themselves and how this may influence the service as well as the clients. I have argued that each of the professions has a culture, each with its own language and ways of understanding its work. Yet it would appear from this research that the cultural boundaries between professions are not as great as has been assumed. Mental health professions may well form their own shared culture. Further, if they began to communicate better with one another, then they may be able to determine for themselves the amount that they have in common. However, such an initiative would probably evoke many negative emotions for each of the professional groups and such an enterprise is unlikely to occur in other than a few very special settings. In this sense, the theory of personal constructs is very useful in understanding such situations and perhaps provides a powerful tool for administrators in acting on mental health policy. This observation leads on to the practical implications of this research.

10.5 THE PRACTICAL IMPLICATIONS OF THE RESEARCH

The most useful finding of this research has been that the three mental health professions participating in this research are more similar than they are different in how they make sense of their work with clients. I would argue that the findings of this research are generalisable to other mental health professionals, for the reasons already mentioned. This finding has practical implications for both mental health service provision and professional training and I shall deal with each in turn.

10.5.1 The Practical Implications of the Research for Mental Health Service Provision

This research suggests that each of the professions are more similar than they are different from each other. When this is assumed to be the case, then for service administrators the important issue is to have individuals who can work together well, rather than to determine services by the composition of different professions. This supports government policy in Australia for the introduction of mental health workers who can be drawn from a variety of professions. In practice there does not appear to be any mechanism in place that determines what are the desirable attributes of professionals in particular work settings. Applicants take up positions often by happenstance, rather than by a process that determines those attributes best suited to the work required by the service.

My experience has been that even when government policy is philosophically in line with generalist mental health workers, the service administrators responsible for such policy implementation

appear to be threatened by such moves. It may be that such a position challenges the traditional “pigeon holing” of professionals by service administrators. Also it is the service administrators that, I would argue, have to deal most closely with the professionals in their service. These professionals, for reasons that I have mentioned, may well be opposed to the generalist workers and make demands on administrators for professional protection.

A further complication with such policy implementation is, that in this state at least, most Directors of Mental Health Services are psychiatrists. Psychiatrists tend to be more biologically orientated and do appear threatened by other professions. This situation could have the potential to influence the type of services that are delivered to clients. The practical implication, then, is policy makers need to be aware of the potential barriers to the implementation of their policies. Personal construct theory has been shown to be useful for this purpose. Policy makers need to liaise more closely with service administrators to overcome these barriers to policy implementation that would benefit the treatment afforded clients. Policy makers and service administrators, must at some stage confront the many difficulties that have arisen during the transition of services from the traditional mode of care to the community-based model.

My research also highlights some of the difficulties for professionals working in comprehensive mental health services. This issue is one that must be addressed by administrators if services are to run smoothly, meet the needs of the clients and protect the staff from burn-out. Service providers need also to liaise with educational bodies, so that what the services require in

mental health are being provided by the educational bodies. There is no point in educators working in isolation from the services in which the professionals they are training will be working. Similarly service providers need to ensure that the working environment of professionals is appropriate for them to function to the best of their ability.

10.5.2 The Practical Implications of the Research for Training of Mental Health Professionals

This research also has a number of implications for the training of mental health professionals. First, if the assumption is correct that the mental health professions are more similar in construing their work with clients than they are different, then the question needs to be asked: What is it that is being imparted to professionals in their training program? I have argued that the most powerful concept that is imparted to professionals is what is expected of them in their role for each of the professions. There is evidence that professionals develop a system of constructs that can distinguish clients, but this system is not well structured, nor is it different for each of the professions. A shortcoming then of current training programs may be that they are attempting to impart to each profession what is expected of them without really paying attention to the fact that each individual comes into training with a system of constructs that is likely to predispose them to accommodating certain facts while discarding others. Because of this, the desired outcome of training, as perceived by the educators, may not be the outcome that the professionals take from their training.

It is easier to accommodate what is expected of professionals in a role than it is to accommodate how you make sense of what you actually do when you are faced with working with clients and colleagues. The latter is an experience that is largely determined by your past experiences of interacting with people. In fact the participants in my research were generally quite critical of their theoretical training and more supportive of their practical training. I would suggest that in theoretical training, trainees are encouraged to learn facts that are based on certain theories that may not be compatible with their construction of the world. In the case of practical training, it is much more likely that the professional will be able to approach their practical work with those aspects of their training with which they feel most comfortable. It would perhaps be advantageous for educators to emphasise that some trainees will feel more comfortable with some theories or sets of assumptions than others and not try to enforce learning of approaches that are beyond their range of convenience. Educators could try to encourage them to develop this awareness so they can concentrate on their professional development and therefore obtain more from their theoretical training than they are currently receiving.

My findings also support the introduction of a basic core of multidisciplinary training for all mental health professions. Such a training format would enable the communication to take place between professions that I identified as important earlier. It would also provide a better understanding of each profession by the other and hopefully help to break down the false boundaries that appear to be operating in practice. The assumption that clients can be labelled “to be seen by the psychiatrist”, “to be seen by the

psychologist” or “to be seen by the nurse” would appear to be artificial boundaries that serve little purpose in practice. There would also seem little argument against the current practice of advertising for generic mental health workers.

However I suggest that the implementation of such practices would be met with considerable hostility on the part of the professions involved. Mental health services are currently shrinking, resources are scarce and each profession feels threatened by the members of other professions. The result, as I have mentioned elsewhere, is that each profession is becoming more specialised, trying to make the services they have to offer unique. The professional bodies are becoming more and more professionalised. To advocate a position that would be in direct contrast to this, would not be accepted by many and indeed actively resisted.

However, it is becoming increasingly clear that professionals are moving away from the world view of their clients, and in fact training may be moving away from the world view of the trainee. There appears to be an increasing gulf between the members of each profession and the people they are there to help and this is in part due to the training process each profession undergoes. Surely the time has come that professions acknowledge the overlap in their work and try to work together for the benefit of the client and not the benefit of their profession.

10.6 IDEAS FOR FUTURE RESEARCH

Future research should be directed at examining the questions of this research with much larger and representative samples of mental health professionals from more varied work settings across

Australia. The constructions that professionals develop about their roles that make them unique among the roles of other professions would also be worth exploration.

Future research also needs to address how mental health policies are implemented, as well as take note of the difficulties in such implementation. Certainly more research is needed to understand how training influences professionals work with their clients. From a constructivist perspective it would also be useful to obtain more information on the rather peripheral nature of constructs that professionals use to describe their work with clients and how these constructs relate to the professionals' more central ones. The issue of whether there is a general dimension of construing events that is determined by an individual's awareness of internal or external events has been raised by this research, and therefore also warrants further research.

10.7 CONCLUSION

In conclusion, my research has focused on how mental health professionals make sense of their work with clients. My findings have indicated that at least the three mental health professional groups of psychiatry, psychology and nursing are more similar than they are different when they describe their work with clients. This result has some practical implications for both mental health service provision and the training of mental health professionals. At a time when there are many complex issues to be addressed by mental health policy makers, administrators, professionals and educators, it is encouraging to have the conceptual framework of personal construct theory to help in achieving our aims. This theory has been shown to be useful in understanding these

complex issues. It is also encouraging that mental health professionals appear to have much in common. Hopefully, in the future these two factors will allow for us all to work more closely together for the benefit of our clients and bring us closer to understanding the clients' world view.

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APPENDIX A

THE WORKING WITH CLIENTS GRID

Working with a person:-

	4	3	3	1	2	3	10	1	1	2	2	6
	5	4	11	7	5	8	11	4	7	6	5	7
	8	11	12	8	9	12	12	10	9	10	6	9
1 who has psychotic experiences												
2 who is suicidal												
3 who has exaggerated fears of being harmed												
4 who has problems with drug abuse												
5 who has a great deal of problems with their moods												
6 who has a great deal of anxiety												
7 who has problems with their sexual behaviour												
8 who is preoccupied with physical complaints												
9 who has problems in daily living												
10 who cannot control their behaviour												
11 with whom you feel comfortable												
12 with whom you feel uncomfortable												

APPENDIX B

INFORMATION AND CONSENT FORM

INFORMATION / CONSENT FORM

As a part of my Doctor of Philosophy (Clinical Psychology) degree in the Faculty of Health & Behavioural Sciences, I am conducting research to evaluate how the different Mental Health Professions perceive their clients/patients. The aim of the research is to better understand how the different professions make sense of their work with their clients/patients. Therefore I am particularly interested in your thoughts about your clients/patients and how you feel about them.

I will be conducting interview that will be audiotaped as well as asking participants to complete a repertory grid test and two short questionnaires. I anticipate this take approximately one hour of your time. The information obtained will be totally confidential and no individual participant will be able to be identified. This research has been approved by the Illawarra Area Health Service, the Director of Psychiatric Services and the University of Wollongong Ethics Committee.

If you are willing to participate in the research could you sign the form below. You may withdraw from the research at any time.

Thank you for your attention.

Barbara Tooth.

I (name).....am willing to participate in the research outlined above, and understand that I can withdraw from the project at anytime. I also understand that the information I supply will be strictly confidential and no individual will be able to be identified.

Signed.....

Date.....

APPENDIX C

THE CATEGORISATION SYSTEM FOR THE CONTENT OF THE WORKING WITH CLIENTS GRID

THE CATEGORISATION SYSTEM FOR THE CONTENT OF THE WORKING WITH CLIENTS GRID

The repertory grid used in this research was a 12 x 12 grid with fixed elements and triadically elicited bipolar constructs. Only the constructs were free to vary. The instructions given to participants were as follows:-

“I want you to think of working with these three clients and tell me how working with two of them is similar but different from the third”.

A total of 720 bipolar constructs were obtained from completion of the grids. The participants were also asked to rate each of the elements on the constructs using a 7 point scale. This data has been analysed for structure by the sociogrid program and forms another part of this research. This program does not make full use of the content of the constructs and the content as such is not of real importance to the application of the sociogrid program. Hence it has been necessary to devise a coding system that will allow for more meaning analysis of the content of these constructs and how they vary across the different professional groups. In keeping with Kelly (1955) the emergent pole, that is the pole on which the similarity occurred, was recorded first and is the pole that is used to determine the bi-polar constructs “fit” into specific categories. The use of the emergent pole is justified as the aim of this research is to examine the similarities that exist between professions.

The process of devising a classification system for these constructs has not been easy. However, six categories did appear to

consistently relate to the data. These categories and the classification necessary for each are those that had the most meaning for me as the researcher. The categories do represent a “clinical” view of the data and this is consistent with the work of Winter (1992) who reports that “professionals’ constructions of their clients often involve psychiatric diagnostic constructs” (p187).

The six major categories and their subcategories are :-

1. CLIENT CHARACTERISTICS

- a) symptoms
- b) clients’ reactions to mental health problems. This is further divided into positive and negative reactions.
- c) clients’ stable personality variables, again further divided into positive and negative categories
- d) clients’ ability or inability to control their behaviour
- e) clients’ ability to cope.

2. PROFESSIONAL SKILLS AND RESOURCES

- a) professional ability
- b) professional inability

3. PROGNOSIS

4. ASSESSMENT

5. PERSONAL FEELINGS

- a) Comfort
- b) Discomfort
- c) Therapeutic relationship-positive
- d) Therapeutic relationship-negative

6. INTERVENTION

- a) Psychologically orientated- cognitive
 - behavioural
- b) Medically orientated
- c) Immediate need

The following tables give a detailed description of the classification criteria for each category. The aim of the research is to better understand how the different professions make sense of their work with their clients/patients.

Table 1. Major Category of Client Characteristics with Subcategories and Examples

Subcategory	Example
Symptoms	This subcategory is scored when the professional refers to constructs that refer to the clients symptoms. For example: depressed, have delusional side, anxious, neurosis, psychosis, unstable, lost touch with reality, paranoid, organically impaired, abnormal, preoccupied, less rational, impulsive etc
Clients' Positive Reactions to their Mental Health Problem	This subcategory is scored when the professional refers to constructs that refer to the clients positive reactions to their mental health problem. For example: client is open to change, client has clear problem, client expresses needs etc.
Clients' Negative Reactions to their Mental Health Problem	This subcategory is scored when the professional refers to constructs that refer to the clients negative reactions to their mental health problem. For example: invoke social control, solve problems by physical means, client does not take responsibility, problems with realities of life, not dealing with problems, deny problems, need to learn how to handle situation etc
Attributed Positive Personality Variables	This subcategory is scored when the professional refers to constructs that refer to the clients positive personality variables. For example: flexible with ideas, self-assertive, concerned for others, capable of initiative, have insight etc

Subcategory	Example
Attributed Negative Personality Variables	This subcategory is scored when the professional refers to constructs that refer to the clients negative personality variables. For example: devious, distrustful, may not be honest, limited ability to interact socially, client feels incompetent, preoccupied with self, low self esteem, entrenched behaviour etc
Clients' Ability to Control their Behaviour	This subcategory is scored when the professional uses constructs that refer to the clients' ability to control their behaviour. For example: has control over their behaviour, client has responsibility for what happens etc
Clients' Inability to Control their Behaviour	This subcategory is scored when the professional uses constructs that refer to the clients' inability to control their behaviour. For example: can not control behaviour, loss of control, problem of self control, need control over experiences etc.
Clients' inability to Cope	This subcategory is scored when the professional uses constructs that refer to the clients' inability to cope. For example: can't cope, not coping, poor coping skills, require a lot of attention etc.

Table 2. Major Category of Professional Skills and Resources with Examples

Professional Ability	This subcategory is scored when the professional uses constructs to refer to their professional ability. For example: I can organise, I can deal with, familiar problem, I know about, easier to work with, I can help, easy to treat etc.
Professional Inability	This subcategory is scored when the professional uses constructs to refer to their professional inability. For example: I am not in control of the situation, difficult to deal with, worry about treatment outcome, I don't feel confident, have a lack of knowledge, difficult to deal with, apprehension of failure, I can't get anywhere with etc.

Table 3. Major Category of Prognosis with Examples

Prognosis	This category is scored when the professional uses constructs to refer to the clients' prognosis. For example: on-going problem, chronic problem, acute problem, short term, long term, poor prognosis, good outcome etc.
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Table 4. Major Category of Assessment with Examples

Assessment	This category is scored when the professional uses constructs to refer to assessment issues that imply the need for assessment. For example: greater risk of criminal offences, more difficult or extensive problems, social problems, no physiological problem, less urgent problem, social problem, less severe problem, primarily affective, medical component, daily living problem etc.
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Table 5. Major Category of Professionals' Personal Characteristics with Subcategories and Examples

Professionals' feelings of comfort	This subcategory is scored when the professional uses constructs to refer to their own feelings of comfort. For example: I like working with, I feel comfortable, rewarding, I like working with et.
Professionals' feelings of discomfort	This subcategory is scored when the professional uses constructs to refer to their own feelings of discomfort. For example: fatiguing, could place me in danger, irritating, make me feel anxious, I feel unsafe, frightened, overwhelming, I get annoyed with etc
Positive therapeutic relationship	This subcategory is scored when the professional uses constructs to refer to positive aspects of the therapeutic relationship. For example: can relate to, feel empathic to, I can understand, have confidence to connect with, etc
Negative therapeutic relationship	This subcategory is scored when the professional uses constructs to refer to negative aspects of the therapeutic relationship. For example: hard to understand, I don't know where they are at, difficult to relate to, not congruent with me etc

Table 6. Major Category of Intervention with Subcategories and Examples.

Psychologically orientated (Cognitive)	This subcategory is scored when the professional uses constructs to refer to cognitive type issues in intervention with clients. For example: addressing belief systems, working with emotional reactions, client focussed, may require confrontation, need to teach to feel OK, foster insight, reassurance, problem solving etc.
Psychologically orientated (Behavioural)	This subcategory is scored when the professional uses constructs to refer to behavioural type issues in intervention with clients. For example, use behavioural skills, limit setting, need for behavioural control, anxiety intervention, require practical assistance/training etc.
Medically orientated	This subcategory is scored when the professional uses constructs to refer to medical type intervention. For example: need medication etc.
Immediate	This subcategory is scored when the professional uses constructs to refer to the need for immediate intervention. For example: can self harm, need observation, need to resolve crisis, provide safe environment, at risk, danger to self, serious problem etc.

APPENDIX D**INSTRUCTIONS FOR THE CODING OF TRANSCRIPTS**

INSTRUCTIONS FOR THE CODING OF TRANSCRIPTS OF INTERVIEWS.

Participants in this research, mental health professionals, were asked questions about their relationships with their clients and what they thought were their most important influencing factors in working with them. Additional questions relating to what they thought influenced their relationships with clients and the role their training had played were also asked. The questions were as follows.

Question 1. I want you to tell me about one of your most successful clients and what you think were the most important factors accounting for that success?

Question 2. I want you to tell me about a client with whom you have had little success and what you think would have enabled you to succeed with this person?

Question 3. What do you think are the most important factors that influence the way you think about clients?

Question 4. What role has your training played in all of the above?

Background to the research

The rationale for asking these questions

Very little is known about what professionals think influences how they work with clients. Research addresses outcome of therapy and the effectiveness of different types of therapies but does not

address the underlying assumptions implicit in the development of multidisciplinary therapeutic interventions for people who have mental health problems. For example, because a multi-modal approach to treatment makes common sense in the interventions of complex problems, it does not necessarily mean that those professionals who make up the team providing these different therapeutic approaches construe or approach them in the same way. We must explore these differing professional perspectives if a comprehensive professional service is to be provided to meet the needs of our clients.

Another one of these professional assumptions is that, although the client is seen as having complex problems, these problems presumably can be divided up into neat categories that can be labeled “for intervention by psychiatrist”, “for intervention by nurse”, “for intervention by psychologist” and so forth. Then each profession can provide its expertise and the clients’ problems will be relieved. There are a number of significant points that arise from this procedure and only some of them can be addressed here. First, who decides about who is to be involved, is an obvious issue, but it is not central to this thesis. Second, the fact that most of these clients have difficulty testing reality raises the question of, in times when a simplistic, or should I say stimulus reduced environment is needed, how do they deal with multiple professionals? In a sense this is not central to my thesis either, but professionals’ views of their relationships with clients is, and surely this must be a part too. Third, and following on from the last point, if the theoretical stance is taken that professionals need to share the same world view as their clients to be truly effective in therapy, then surely there needs to be some commonality in approach

between different professionals, or an acknowledgement of differences and some ways to resolve conflict, for comprehensive interventions to be effective. However, before these issues can be addressed at a team level we need to know whether each of the professions are similar or different in their understanding of the relationships they have with their clients.

Decisions made regarding the analysis of responses to each question

No previous research has been undertaken using interviews to address the research questions. It has therefore been necessary to devise a method of analysis and coding of the data. In doing so it is important to point out that these categories have been identified by my interpretation of what participants have told me. Likewise the organisation of these categories is according to what makes the most sense to me about what I have been told.

The first two questions asked of the participants encouraged them to talk about a particular client they had worked with so they could remember or refamiliarise themselves with the contact they had with this person. They were then asked to talk about what they thought were the most important factors accounting for the success and failure they had experienced with these clients. To analyse the content of these questions, the first part in which they spoke about their clients to refamiliarise themselves, was treated as preamble, or more specifically as their providing their own case vignette on which to reflect for the important factors in the relationship. *For the purpose of scoring, only the important factors accounting for the therapeutic outcome are to be scored.*

The first two questions are then analysed under three broad headings. The first is *professional characteristics*, the second is *client characteristics* and the third is *other factors*. Each of these categories is then further subdivided into more descriptive categories and each of these large and smaller categories have been given a number to allow them to be indexed and analysed by the NUDIST (Richards & Richards, 1989) computer program for qualitative data analysis (a detailed description of this program follows). The categories and their indexing codes used in this research are as follows.

Responses to the third question, asking the participants more directly about what they thought influenced how they worked with clients, is also to be scored and indexed according to the above scoring system.

Responses to the fourth question, asking the participants what role their training had played in how they worked with clients, is scored and indexed in three main categories. These are factors relating specifically to *training*, the participants' own *personal factors* and again a miscellaneous category for *other factors*.. In keeping with the coding and indexing system, these categories are also further subdivided and given a number code.

NON-NUMERICAL UNSTRUCTURED DATA INDEXING SEARCHING and THEORISING (NUDIST) COMPUTER ANALYSIS

The NUDIST computer program was designed for the qualitative analysis of unstructured data of any kind. It uses a tree structured indexing system to enable concept-building about a particular project. The categories can occur as "nodes" of indexing tree

hierarchies. This is diagrammatically represented in Figures 1-4 of the scoring procedure. The program uses numbers that are attached to each category and sub-category. In other words the text is “flagged” so that it can be identified by the computer.

Numbering of the index codes

It is necessary to use Figures 1-4 to obtain the correct number for each category and subcategory. The first number represents the major category, followed by the next appropriate subcategory and so on down the indexing tree. It is in this sense that the indexing tree is hierarchical in nature. For example a participant who made a response to Question 1 such as “the reason I think the therapy was successful was because of the relationship I had with the client and the fact that I validated a lot of their experiences”, would be scored as follows:-

111 professional characteristics / professional relationship / confirming.

It is important to point out that there is no special relationship between the various categories or the subcategories in the index tree. The NUDIST program was chosen because it goes beyond the “string-search” and “flagging” techniques, enabling greater flexibility in the analysis of the data.

PROCEDURE

Figures 1-4 provide the indexing codes for the analysis of the data. These codes are to be used to score the transcripts of the tape-recorded interviews conducted with each participant. Examples of each of these categories and sub-categories follow in Tables 1-4

and can be used in conjunction with the diagrammatic representation of the indexing trees. The scorer is to put the *number code* of each category in the column beside the occurrence of that category. The numbering code is also included in the example section.

The only prompt used throughout the interviews was the repeat of the initial question if the participant either requested it or if it was desired that the participant elaborate on their answer.

Question 1, 2 and 3 are scored using the major categories of Professional Characteristics, Client Characteristics and Other Factors and their respective subcategories. Question 4 is scored using the major category of Training only.

Table 1. Major Category of Therapist Characteristics with Subdivisions, Examples and Scores.

Subcategory	Division	Example	Score
Therapeutic Relationship	Confirming	Therapist uses constructs such as validation, listening or empowering the client. eg "I think just listening to the client was important" or "that I was able to reassure or validate what the person had been going through" or "I was able to make the client feel that they had more power to deal with their situation"	111
	Rapport	Therapist uses constructs such as rapport, being in tune with client, understanding the client, working with the client or co-operating with the client. eg "I think the rapport we had was important" or "the fact that I understood what the client was saying was important" or "the fact that we worked together, co-operated" or "I can identify with the client".	112
	Trust	Therapist uses constructs such as security, availability or trust as important eg "I think just being available was important" or "that the client trusted me was important" or "the fact that the client felt secure having someone to talk to".	113
	Lack of rapport	Therapist uses constructs such as having different goals to the client, not understanding why the therapy was not working, not knowing what they were dealing with with the client, having no empathy/rapport with the client or being unable to relate to the client eg "the clients' goals were different to mine" or "I don't really understand why the therapy didn't work" or "I think it didn't work because I wasn't what I was dealing with with the client" or "I just couldn't establish a relationship with this person or relate to them".	114
	Desperation	Therapist uses constructs such as hopelessness when referring to client or suicide of client.eg "I don't think you can be successful with these sort of clients" or "we don't have any successes here or very few" or "you tend to think of the ones that suicide, they're failures".	115

	Initial reactions	Therapist uses constructs that refer to their initial reactions to the client or how the client was referred eg “my first reactions to a client are important, how they dress, if they are clean or good looking” or “how a client is referred to me is important” or “what the referral has told me about the client is important”.	116
Personal	Acceptance	Therapist uses constructs such as acceptance of the client, being non-judgemental, giving the client permission to be themselves or do whatever they need to do, or caring eg “I think that I accepted the client as they were was important” or “that I gave the client permission to do what they needed to do or to be themselves” or “that I cared for the client was important” or “I think of them as people, not choosing to be this way”	121
	Flexibility	Therapist uses constructs such as flexible or unconventional eg “I think that I was able to use unconventional methods was important” or “that I was able to be flexible with the client”.	122
	Expectations	Therapist uses constructs relating to their expectations eg “I think it is important to lower your expectations or change your expectations of clients for them to be successful” or “if my expectations were lower then I probably wouldn’t see people as failures”.	123
	Adequacies (personal)	Therapist uses constructs that are positive to describe why they are able to work with people eg “I think that I am aware of my own feelings and do not let them interfere is important” or “I am aware of the countertransference issues is important”.	1241
	Adequacies (professional)	Therapist uses constructs that refer to professional training or having a mentor eg “I think that my training was important in the success” or “I think that I learnt a lot from and influential teacher and that has influenced how I work and made me more successful with clients” or “I think work experience is important”.	1242

	Constructions of self	Therapist uses constructs to describe themselves, such as their desire to help, their values, religious beliefs or having a sense of purpose eg "I think it is what I believe about people, my values in life that are important" or "I think my religious beliefs are important" or "I think because I really want to help people or have a sense of purpose in what I am doing that makes me successful" or "my upbringing is important".	125
	Constructions of client	Therapists use constructs to describe their beliefs about their clients eg "I think that I believe that my clients can change is important".	126
	Life experience	Therapist uses constructs to refer to their own life experience eg "I think that my own life experiences help me help clients" or "I think if I have had similar experiences to the client then I am able to help them more".	127
	Inadequacies (personal)	Therapist uses constructs that indicate their own personal inadequacies such as impatience, being enmeshed with the client eg "I think I would have succeeded if I had been more patient" or "I think if I hadn't been so involved with the client".	1281
	Inadequacies (professional)	Therapist uses constructs to refer to inadequacies in their training, the need for supervision, their own self-doubt about their skills or the need to discuss clients with other professionals eg "if I had had supervision maybe I would have been more successful" or "maybe if I had more skills I would have been successful" or "maybe if I had more training".	1282
Intervention	Assessment	Therapist uses constructs relating to assessment or accurate diagnosis eg "I think one of the important factors is making sure the client has had a proper assessment" or "I think making sure that the clients' diagnosis is accurate is important".	131

Program (positive)	Therapist uses constructs that refer to the program of intervention in a positive way eg "I think the fact that the program was good and we reached our goals" or "that the program was intensive was important" or "the fact that we were able to use community treatment enabled us to succeed" or "I think because the family were involved make it successful" or "the fact that I provided the client with education was important" or "the medication was important" or "the fact that we had time was important".	1321
Program (negative)	Therapist uses constructs that refer to the program of intervention in a negative way eg "if the approach had been problem orientated or we used a behavioural approach it would have been successful" or "I think the only thing that would really work is medication" or "I think the person needed more education about their disorder" or "if the family were involved it would be more successful" or "I think they needed long-term admission".	1322
Follow-up	Therapist refers to follow-up as important eg "the fact we were able to assertively follow-up the client was important".	133

Table 2 Major Category of Client Characteristics with Subdivisions, Examples and Scores.

Subcategory	Division	Example	Score
Descriptive		Therapists uses constructs to describe client such as age or intelligence eg “I think that the clients’ age made a difference” or “I think because the client was intelligent was important” or “the clients’ appearance was important” or “the clients’ attitude was important”.	21
Prognostic	Positive	Therapist refers to positive aspects of clients’ mental health problem eg “success is if the client does not come back into the unit” or “it was successful because the person did not have a psychosis or they were not debilitated or it was a situational problem”.	221
	Negative	Therapists refers to negative aspects of clients’ mental health problem eg “it was not successful because the person was psychotic so you couldn’t communicate with them” or “the client had an organic problem so you really couldn’t do much” or “I think the only thing that would work is medication”.	222
	Descriptive	Therapist refers the clients’ mental health problem in more descriptive terms eg “It really depends on the severity of the disorder to determine success” or “the diagnosis usually indicates if you can have success or not” or “usually the clients’ history gives an indication if you can be successful or not” or “the degree of distress the person is in is important”.	223
Personal	Positive	Therapist refers to positive aspects of the clients’ personal qualities eg “I think because the client had insight was important” or “the client was motivated, ready to do something about their problem” or “the client was open and honest, took responsibility for themself”.	231
	Negative	Therapist refers to negative aspects of the clients’ personal qualities eg “the client was manipulative and not motivated to change or not prepared to is the reason it was not successful” or “the client would not comply with what was asked of them” or “the clients’ drug problem was the main factor” or “the client had a lot of dependency needs that didn’t help” or “I think the client has just copped out”.	232

Table 3. Major Category of Other Factors with Subdivisions, Examples and Scores.

Subcategory	Division	Example	Score
Physical	Positive	Therapist refers to factors such as accommodation or basic human needs being met as important eg "I think just having somewhere to live, food and somewhere to go to socialise are important to succeed".	311
	Negative	Therapist refers to factors such as accommodation not being met as reason for failure eg "I think if the person had somewhere to live or was able to get a job and go out and socialise then it would have been successful".	312
Social	Positive	Therapist refers to clients' social supports or family as important for success eg "I think the fact that the family were very supportive was important" or "I think because the person had a lot of support was important".	321
	Negative	Therapist refers to clients' lack of social support or family involvement as reason for failure eg "I think if the family had been involved it would have been successful" or "if the person just had more support we may have been able to succeed" or "getting away from the family situation would have helped" or "the family meant well but" or "they had to go back to the same environment so my impact was minimal".	
Service	Positive	Therapist refers to their work setting as important factors in the success eg "I think it is because of the environment here that makes it successful" or "I think this type of service is why it is successful".	322
	Negative	Therapist refers to difficulties within the service as reasons for failure eg "I think if we had more time to be with the clients it would be successful" or "I think if we had more resources it wouldn't have failed" or "I think if the services were better co-ordinated then I think it would have been more successful" or "I think if there were more consistency between staff then it would have succeeded".	331
Cultural		Therapist refers to the clients' cultural background important eg "I think because the person was from an ethnic background made a difference in the outcome"	332

Table 4. Major Category of Training with its Subdivisions, Examples and Scores.

Subcategory	Division	Example	Score
Formal	Theoretical (positive)	Therapist refers to formal training as very important to how they work with clients eg “I think my training has played an enormous role, I wouldn’t be able to do what I do if it wasn’t for my training” or “it has been important because it has given me a way of thinking about what I do”.	4111
	Theoretical (negative)	Therapist refers to formal training in a negative way eg “I don’t think it has had any influence in how I work with clients” or “I think my training was a very negative experience and I don’t think it taught me anything about how to work with clients” or “the training lacks integration with experience” or “the training is really very poorly structured”.	4112
	Theoretical (basic)	Therapist refers to training as providing a basis only from which to work eg “I think my training has really only given me the very basic knowledge from which to work” or “it gave the information about the disorders and the medications and how to assess people but it hasn’t really given me in information on how to work with people” or “you could get all this sort of information out of a textbook”.	4113
	Practical (positive)	Therapist refers to practical training as important eg “I think the clinical/practical work is the most important as you can do it for yourself” or “it is not until you start working with people that you really learn what you are doing” or “having a mentor is important”.	4121
	Practical (negative)	Therapist refers to negative aspects of practical training eg “I don’t think your training prepares you to work in the community” or “I think that the training has too narrow a focus” or “I think the training should include personal work and/or specific therapy training” or “it doesn’t prepare you to work with other staff”.	4122

Informal		Therapist refers to informal training as important eg “I think just being able to talk to your colleagues is important”.	42
Personal	Experience	Therapist refers to their own life experiences eg “I think my own life experiences have been important in how I work with people “ or “I think my background, how I was brought up and the experiences I have had before I ever came into this work are important”.	431
	Personal growth	Therapist refers to their own personal growth as important eg “I think that as a therapist you have to really know yourself and be able to deal with your own issues before your can work with clients” or “I think that you really need to attend to your own personal growth” or “I think doing personal growth workshops in your training is important”.	432
	Values	Therapist refers to their personality as important eg “I think who you are as a person is important in how you work with clients” or “it is my personality that is important” or “it is my philosophy of life that is important”or “it is my values that are important”.	433

APPENDIX E

THE INTERVIEW SCHEDULE

THE INTERVIEW SCHEDULE

I would like you to talk freely and for about five minutes on each of the following questions.

Question 1. I want you to tell me about one of your most successful clients and what you think were the most important factors accounting for the success.

Question 2. I want you to tell me about a client with whom you have had little success and what you think would have enabled you to succeed with this person.

Question 3. What do you think are the most important factors that influence the way you think about clients?

Question 4. What role has your training played in all of the above?